<Date>
<Payer Name>
<Payer Address>

Re: Appeal of Denied CAR T Coverage

Patient Information	Reference Number	CAR T Cell Therapy	Denial Date
Patient: <Patient Name> Group/Policy Number: <Group/Policy Number> Date of Birth: <Date of Birth>	<Denied PA or Claim Number>	<CAR T Product Name>	<Denial Date>

To Whom It May Concern:

I am writing on behalf of my patient, <Patient Name>, to request <First-Level/Second-Level> Appeal by an Oncology Medical Advisor to reconsider denied coverage for <CAR T Product Name> for <patient's diagnosis>. According to your letter dated <Denial Date>, coverage was denied due to the following reason:

- <Quote denial reason as stated in the denial letter>

The following is a brief description of the patient's medical history:
<Outline relevant details to document medical necessity, including:

- Primary diagnosis and ICD-10-CM code
- Relevant disease-related characteristics (eg, histology, prognostic factors)
- Prior regimens/lines of therapy and treatment response
- Clinical fitness (eg, ECOG performance status, organ function indicators)>

Based on my clinical judgment and the supporting evidence, as outlined below, I believe that <CAR T Product Name> is warranted, appropriate, and medically necessary for <Patient Name>:
<Summarize rationale for treatment, including supporting evidence from:

- Prescribing Information
- Treatment guidelines and/or recognized drug compendia
- Peer-reviewed literature>

In view of the above information and the enclosed documentation, I believe <CAR T Product Name> should be covered for this patient's medical condition.

Sincerely,

<Provider Name and Signature>
<Provider Identification Number and Contact Information>
<Treatment Center Name and Address>

Enclosed Documentation:
<Attach and list pertinent documentation, as appropriate>