[Insert Physician Letterhead]

[**Sample Letter of Appeal**
This template is intended to be used as a resource. It does not guarantee coverage. Please use your discretion to modify any content in the template based on your medical judgement; you may also write your own. Remember to remove all instructions before saving the document.]

Attn: [Insert Name of Medical Director]
[Insert Payer Name]
[Insert Address]
[Insert City, State, ZIP]

RE: [Insert Patient Full Name]
[Insert Gender and Date of Birth]
[Insert Policy and Group Numbers]
[Insert Claim Number]

REFERENCE NUMBER: [Insert Reference Number]
THERAPY: TALZENNA® (talazoparib) [insert dose, frequency, and days supplied]
SUBMISSION DATE: [Insert submission date]
DENIAL DATE: [Insert denial date]

[Insert Date]

Dear Medical Reviewer/Appeals Reviewer:
I am writing on behalf of my patient, [insert patient name], to request a [insert either first-level appeal or second-level appeal] by an Oncology Medical Advisor of the prior authorization denial of the above-referenced line item(s). It is my understanding based on a letter of denial dated [insert date] that TALZENNA® has been denied because [insert quote of specific reason for the denial stated in the denial letter].

This case involves my patient, [insert patient name], who was diagnosed with [insert diagnosis (e.g., mCRPC) and ICD-10-CM code] on [insert date]. I believe that [insert patient name] would benefit from TALZENNA®. Please see the enclosed documentation that discusses [insert patient name]'s medical history and supporting information in more detail, as well as the prescribing information for TALZENNA®.

The following items are enclosed:

- [Insert laboratory/imaging results and pathology reports]
- [Insert medical records documenting treatment history]
- [Insert published articles and clinical guidelines (i.e., American Society of Clinical Oncology [ASCO] and National Comprehensive Cancer Network [NCCN])
- [Insert applicable coverage policies]

The enclosed information supports the claim that TALZENNA® is medically necessary. I strongly believe this treatment should be covered and request that you reconsider coverage based on the information provided. Due to the acute nature of this disease, I would appreciate your prompt review of this [insert initial or second] appeal.

Please contact me at [insert phone number or e-mail address] if you require any additional information or documentation. I look forward to your timely response.

Sincerely,
[Insert physician name and participating provider number]

Enclosure: [Include full Prescribing Information and any additional supporting documentation]

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