—SAMPLE —

This letter is only intended as a TEMPLATE Letter of Appeal for BIXLENVO™

INSTRUCTIONS: MUST BE ON HEALTHCARE PROVIDER'S LETTERHEAD AND MUST BE COMPLETED AND SUBMITTED BY THE HEALTHCARE PROVIDER. Please see the full Prescribing Information, including **BOXED WARNING**, at www.BIXLENVOhcp.com.

This sample letter is provided for your guidance only. It provides an example of the types of information that may be provided when responding to a request from a patient's insurance company to provide such a letter. Use of the information in this letter does not guarantee that the health plan will provide reimbursement for the medication and is not intended to be a substitute for or to influence the independent medical judgment of the physician.

[Healthcare Provider's Stationery] [Insert Date]

[Medical Director] [Insurance Company] [Address]
[City, State ZIP]

RE: Denial of Coverage for BIXLENVO for HIV-1 Infection Use
Patient Name: **[Insert Patient Name]**
Policy Number: **[Insert Policy Number]**
Claim Number: **[Insert Claim Number]**
Subject: Appeal of Denial of BIXLENVO

Dear **[Insert Medical Director's Name]**:

On behalf of my patient, **[patient name]**, I am writing to request reconsideration of your denial of coverage of BIXLENVO for **[INDICATION]**. I have read and acknowledged your policy for responsible management of drugs for **[INDICATION]**. Your reason(s) for the denial **[is/are] [reason(s) for the denial]**.

Based on the patient's condition and medical history, as well as my experience prescribing HIV-1 medication, I believe prescribing BIXLENVO is warranted, appropriate, and medically necessary in this case. Please see my clinical reasoning below.

[Patient diagnosis and medical history in support of the appeal]

[Name of patient] has maintained virologic suppression; however, continuation of the current regimen is **not clinically appropriate** due to **[insert brief reason(s)]**.

[Provide a brief discussion of patient's history and current condition, laboratory results, and supporting documentation as requested by the plan in their denial letter, highlighting those factors leading you to recommend the use of BIXLENVO].

In summary, this is my [**level of request**] prior authorization appeal. A copy of the [**level of denial**] denial letter is included along with my medical notes in response to the denial. **[Conclusion statement regarding whether BIXLENVO is appropriate and medically necessary for the patient.]** Please contact me at **[healthcare provider's telephone number]** or via email at **[healthcare provider's email]** if you have any further questions about this matter.
Thank you for your time and consideration.

Please see the Full Prescribing information for BIXLENVO at www.BIXLENVO.com/hcp.

Sincerely,
[Healthcare Provider's Signature]

[Healthcare Provider Name]
[Provider Identification Number]
[Phone Number]

[Enclosures: [List enclosures, which may include: BIXLENVO prescribing information; the patient's explanation of benefits/denial letter; copies of original claim form; a letter of medical necessity; clinical notes/diagnostic lab reports; medication records; relevant laboratory reports; and any other relevant supporting documentation]

This sample letter is for general information purposes only and is not intended, and does not constitute, legal reimbursement, business, clinical, or other advice. Use of this template or the information in this template does not guarantee reimbursement for coverage. Coverage and reimbursement may vary significantly by payer plan, patient, and other factors. The information provided is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional. Responsibility for ensuring the accuracy of information included in any communication between the healthcare provider and the payer remains solely with the healthcare provider.