Sample Letter of Appeal for JUXTAPID® (lomitapide) capsules

This sample letter is intended as a general guide for requesting reconsideration for denied claims of JUXTAPID. It is the prescriber's responsibility to verify and ensure the accuracy of the content included in the letter. All information that is provided to payers must be truthful and accurate. ***Use of the information in this letter does not guarantee that the payer will provide coverage for JUXTAPID and is not intended to be a substitute for, or an influence on, the independent medical judgment of the prescriber.***

For additional information, please contact Compass at 1-85-JUXTAPID (1-855-898-2743) Monday through Friday from 8AM - 7PM ET. Visit JUXTAPID.com to download a copy. Please see full Prescribing Information including Box Warning available at JUXTAPIDpro.com and https://protect-us.mimecast.com/s/cZ9RC4xWr0tEjgQIODbdi?domain=juxtapidpro.com.

[Date]
ATTN: Medical Review
[Contact name]
[Insurance company]
[Insurance street address]
[Insurance city, state, ZIP]

Re:
[Patient name]
[Date of birth]
[Policy #]
[Group #]

Dear [Contact name]:

This letter is sent to request reconsideration of a claim for JUXTAPID® (lomitapide) capsules for my adult patient, [patient name], with homozygous familial hypercholesterolemia (HoFH). In a letter dated [date of denial letter], [Insurance company name] denied this claim because [reason for denial]. I continue to recommend JUXTAPID as my treatment of choice for this patient based on my experience in treating HoFH.

[Patient name] is a [age]-year-old [female/male] who was initially diagnosed with HoFH on [date] and has been in my care since [date]. During this time, [he/she] has been treated with other therapies including [discuss previous therapies and patient's response to therapy].

The decision to use JUXTAPID for [patient name] is based on [provide rationale for the use of JUXTAPID in this clinical case]. Enclosed is additional information, including [list relevant documentation], that supports this treatment decision. I trust this information, along with my medical recommendations, will establish the medical necessity for payment of this claim.

Product Description
JUXTAPID is a microsomal triglyceride transfer protein inhibitor indicated as an adjunct to a low-fat diet and other lipid-lowering treatments, including LDL apheresis where available, to reduce low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high-density lipoprotein cholesterol (non-HDL-C) in patients with homozygous familial hypercholesterolemia (HoFH).

The safety and effectiveness of JUXTAPID have not been established in patients with hypercholesterolemia who do not have HoFH, including those with heterozygous familial hypercholesterolemia (HeFH). The effect of JUXTAPID on cardiovascular morbidity and mortality has not been determined.

Because of the risk of hepatotoxicity, JUXTAPID is available only through a restricted program called the JUXTAPID REMS Program. **JUXTAPID should only be prescribed to patients with a clinical or laboratory diagnosis consistent with HoFH.**

I have completed the necessary training for the appropriate selection and monitoring of patients for the safe use of JUXTAPID per the conditions of the REMS program. I am certified to prescribe JUXTAPID under the conditions of the JUXTAPID REMS Program, and have completed the FDA required patient counseling with [INSERT PATIENT NAME] on the JUXTAPID REMS Program requirements and the JUXTAPID REMS Program Prescription Authorization Form.

Enclosed is the full Prescribing Infomration including Box Warning. Please contact me at [prescriber telephone number] if you require additional information. Thank you for your immediate attention to this very important matter.

Sincerely,

[Prescriber name]

Enclosures
Full Prescribing Infomration including Box Warning
[list enclosures]