[PRACTICE LETTERHEAD]

[Date]

[Name of Health Insurance Company]
[Insurer Address]
[City], [State] [Zip Code]
Attn: Claims Department

Re: [Appeal/Request for Reconsideration]: SUSTOL® (granisetron) extended-release injection, J1627
Beneficiary: [Patient Name]
Policy Number: [ ]
Group Number: [ ]
Treatment Date[s] and Claim Number[s]: [ ]
Total amount of charges filed: [***provide total dollar amount***]

Dear Director of Claims:

I understand that your plan has denied access to SUSTOL for my patient, [Mr/Ms] [***patient name***], for the following [reason/reasons] listed on the attached explanation of benefits (EOB) form: [***list reason(s) from EOB***].
I am writing to request a review of this denial.

[Mr/Ms] [***patient name***] was prescribed SUSTOL for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of [insert the chemotherapy drug(s)], which is/are considered emetogenic.

SUSTOL is the best choice of therapy for [Mr/Ms] [***patient name***], given that [***document the condition and medical needs of the patient, indicating applicable factors that indicate the need for SUSTOL; provide dates of service, outcomes to date, and anticipated outcomes without access to SUSTOL***.]

SUSTOL is a subcutaneously administered antiemetic that consists of granisetron, a selective 5-hydroxytryptamine3 (5-HT3) receptor antagonist, incorporated in an extended-release polymer formation. SUSTOL is indicated in combination with other antiemetics in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic chemotherapy (MEC) or anthracycline and cyclophosphamide (AC) combination chemotherapy regimens.[1] Full Prescribing Information for SUSTOL can be found at www.sustol.com.

Treatment with SUSTOL [will be/has been] necessary to support [Mr/Ms] [***patient name***]'s overall treatment plan, and it is my belief that [he/she] [will benefit/has benefited] from access to this therapy. The relevant documentation of [his/her] medical history is enclosed, along with copies of claims submitted for payment.

Given the facts above, I believe SUSTOL should be covered for this patient. The information enclosed with this request for review, along with my medical recommendation, should be sufficient to establish the medical necessity for payment of this claim.

Sincerely,

[***Physician name***]
[***Physician signature***]

Enclosures:
Copies of patient medical records
Copies of claim forms submitted

Reference: 1. SUSTOL [package insert]. Heron Therapeutics, Inc., San Diego, CA; May 2017.