[PRACTICE LETTERHEAD]

[Date]

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

Re: [Appeal/Request for Reconsideration]: CINVANTI® (aprepitant) injectable emulsion
HCPCS Code: J0185

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 CINVANTI 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 CINVANTI 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 [moderately/highly] emetogenic.

CINVANTI 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*** **CINVANTI*****; provide dates of service, outcomes to date, and anticipated outcomes without access to*** **CINVANTI**.]

CINVANTI is a substance P/neurokinin-1 (NK_1) receptor antagonist, indicated in adults, in combination with other antiemetic agents, for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin and nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC). CINVANTI has not been studied for treatment of established nausea and vomiting. CINVANTI is an intravenously administered antiemetic that is proven equivalent to fosaprepitant for injection; it a polysorbate 80–free injectable formulation of aprepitant.[1] Full Prescribing Information for CINVANTI can be found at www.cinvanti.com.

Treatment with CINVANTI [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 CINVANTI 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. CINVANTI [package insert]. San Diego, CA: Heron Therapeutics, Inc; February 2019.