

Sample Letter of Appeal  
*Patient to convert to OCREVUS or OCREVUS ZUNOVO*

[Date]

[Physician Name]  
[Health Care Practice Name]  
[Health Care Practice Address]  
[City, State ZIP]

[Insured Name and DOB]  
[Patient Name]  
[Patient Insurance ID#]  
[Denial Reference Number]

Dear Medical or Pharmacy Director:

[Patient name] has been treated since [Date] to manage [relapsing forms of multiple sclerosis (RMS)|primary progressive MS (PPMS)]. [He|She|They] [has|have] been on [Drug name] since [Date].

This letter of [insert level of appeal] is a formal appeal of your coverage decision for [OCREVUS® (ocrelizumab)|OCREVUS ZUNOVO™ (ocrelizumab and hyaluronidase-ocsq)]. I request that the [insurance name] denial decision be reversed and coverage approved for [OCREVUS|OCREVUS ZUNOVO], as it is medically necessary to treat the diagnosis of [RMS|PPMS] ([ICD-10-CM code]). The appropriate treatment at this time is to discontinue [Drug name] and to prescribe [OCREVUS|OCREVUS ZUNOVO].

The rationale for prescribing [OCREVUS|OCREVUS ZUNOVO] includes:

- [Reason(s) supporting changing to new drug prescription]

Included with this letter of appeal to be approved to change to [OCREVUS|OCREVUS ZUNOVO] are relevant supporting medical documentation, including a letter of medical necessity, clinical trial information and FDA approval information. [Summarize reasons for the patient to convert to OCREVUS|OCREVUS ZUNOVO]. Please feel free to contact me if I can provide further information or a peer-to-peer review for your approval to overturn your denial and authorize [OCREVUS|OCREVUS ZUNOVO].

Sincerely,

[Physician name]  
[Phone number]  
[Fax number]