[Copy letter onto your practice letterhead]
[This template is customizable and should be tailored to the patient and specific coverage determination.]

[Date]

ATTN: [Contact name/Medical Director]
[Contact name]
[Payer name]
[Payer address]
[City, state, zip]

Re: Letter of Appeal for Lumvoa™ (veligrotug-vvze)
Patient: [Patient first and last name]
Date of Birth: [MM/DD/YYYY]
Policy ID Number: [Insurance ID number]
Policy Group Number: [Insurance Group Number]
Case ID Number: [Case ID number]

Dear [Payer Contact name/Medical Director]:

I am writing to formally appeal the denial and request urgent reconsideration of authorization for Lumvoa for my patient [patient first and last name], whom I have treated since [date] for Thyroid Eye Disease (TED) associated with clinically significant and progressive functional impairment. In the coverage determination dated [date], authorization for Lumvoa was denied due to [insert reason for denial]. Based on my independent clinical judgment, delay or denial of Lumvoa places this patient at risk of clinically significant and potentially irreversible disease progression, including functional and vision-threatening complications.

[Patient name]'s TED care is co-managed with [specialist name, credentials], who has independently evaluated the patient, confirmed the diagnosis and disease severity, and, in their professional judgment, supports prompt initiation of Lumvoa therapy. Further delay substantially increases the risk, and authorization of Lumvoa at this stage is medically necessary and clinically urgent to prevent lifelong impairment.

[I am providing this information as the treating physician, and it reflects my independent clinical assessment of the patient.]

Summary of Diagnosis, Disease Severity, and Prior Treatment

- Diagnosis: [TED]
- ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification): [codes]
- Disease status: [active or chronic]
- Severity: [eg, moderate-to-severe] and [brief description of the patient's current disease state and symptoms]:
    - Clinical activity scores (CAS): [X]
    - Proptosis: [X] mm
    - Diplopia: [Describe, eg, presence and type of diplopia]
    - Lid retraction: [X] mm
    - Risk of vision loss: [Describe]
    - Impact on daily activities: [Describe functional limitations]
- Relevant comorbidities: [eg, Graves' disease]
- [Medically relevant history of all prior treatments and responses to those treatments]
    - [eg, oral/intravenous corticosteroids or other immunosuppressive therapies (dose, duration, response/intolerance)]
    - [eg, use of radiation therapy and/or surgical history, including orbital decompression, strabismus surgery]
    - [eg, reason prior treatments were insufficient, contraindicated, or not durable]
- [Relevant test results and test dates]
    - Thyroid status: The patient is [euthyroid or undergoing treatment to correct mild hypo- or hyperthyroidism to maintain a euthyroid state]
        - Free T3: [value, date]
        - Free T4: [value, date]
- [Other relevant medical history]
- Treatment with Lumvoa is intended to address clinically significant functional impairment and is not for cosmetic benefit

- [Summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with Lumvoa]
- [Clinical rationale for selection of Lumvoa for this patient, consistent with FDA-approved indication and Prescribing Information, based on my independent clinical judgment]

Supporting clinical documentation is enclosed and substantiates that Lumvoa is an appropriate treatment option for [patient name].

Based on my clinical judgment and professional experience, treatment with Lumvoa is medically necessary and consistent with evidence-based standards of clinical practice. I respectfully request that the denial be reconsidered and overturned and that authorization be granted without further delay to prevent irreversible harm.

Should additional information be required, please contact me at [physician phone number] or [physician email].

Thank you for your prompt reconsideration of this appeal.

Sincerely,
[Physician name and credentials]

Enclosures: (attach as appropriate)

- Product information: [Lumvoa FDA-approved indication, Lumvoa Prescribing Information, Lumvoa clinical trial data]
- Physician clinical rationale: [treating physician to describe clinical rationale for selecting Lumvoa for this patient including relevant clinical notes, clinical documentation, medical records, relevant peer-reviewed journal articles, consensus statements/treatment guidelines, and/or Letter of Medical Necessity]