**PHYSICIAN LETTERHEAD**

[Date]

[Medical Director]

[Payer Name]

[Address]

[City, State Zip]

Re: Appeal for denial of CIMERLI® (ranibizumab-eqrn) injection

[Claim number]

[Patient Name]

[Patient Date of Birth]

 [Subscriber ID Number]

 [subscriber Group Number]

 [Case ID Number]

[Date(s) of Service]

Dear [Medical Director]:

I am writing to request that you reconsider your denial of coverage for CIMERLI injection for my patient, [Patient Name] who has been diagnosed with [insert diagnosis]. Attached to this request is the full Prescribing Information for CIMERLI and clinical notes regarding this patient’s disease state.

You have indicated CIMERLI is not covered because [reason for denial].

The rationale for treating this patient with CIMERLI is [Include a description of the patient’s disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision. If the patient has already received treatment with this product, provide a concise but specific description of how this product has benefited the patient. Highlight any documentation that supports your treatment decision].

I believe CIMERLI is appropriate and medically necessary for this patient and will provide treatment**.** Please call my office at [Phone Number] if I can provide any additional information.

I look forward to your prompt review of this request.

Sincerely,

[Physician Name]

[Participating Provider Number]

Enclosures [Attach Original Claim Form, Denial/Explanation of Benefits, and additional supporting documents such as patient’s treatment with CIMERLI, medical history, diagnosis, lab results, and treatment plan, relevant peer-reviewed publications, and CIMERLI prescribing information.]

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