

PHYSICIAN/PRACTICE LETTERHEAD

[Payer Name]

[Date]

ATTN: [Contact Title/Medical Director]

[Contact Name (if available)]

[Payer Address] [City, State ZIP]

Re: Claims Appeal Letter for COSELA™ (trilaciclib)

Patient: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Subscriber ID Number: [Insurance ID Number]

Subscriber Group Number: [Insurance Group Number]

Case ID Number: [Case ID Number (if available)]

Dates of Service: [Dates]

Dear [Contact Name/Medical Director]:

I am writing on behalf of my patient, [Name of Patient], to appeal [Name of Health Insurance Company]'s decision to deny coverage for COSELA (trilaciclib) for injection, which is prescribed to decrease the incidence of chemotherapy-induced myelosuppression in adult patients when administered prior to a platinum/etoposide-containing regimen or topotecan-containing regimen for extensive-stage small cell lung cancer. Based on your letter of denial dated [Date], that coverage has been denied for the following reason(s), [List the Specific Reason(s) for the Denial as Stated in the Denial Letter].

Patient History and Diagnosis

[Provide a Brief Description of the Patient's Medical Condition]

[Include a Short Summary of the Patient's Medical/Medication History]

[Explain why you believe it is Medically Necessary for the Patient to receive COSELA]

[Describe the Potential Consequences to the Patient if they do not receive COSELA]

[Include COSELA Indication Information]

[Include COSELA Administration Information]

Please see the accompanying enclosures and documentation demonstrating the medical necessity of COSELA. I would appreciate a prompt review of this information and authorization of COSELA. I can be reached at [provider phone number] or by fax at [provider fax number] for additional information and discussion. Thank you for your consideration.

Sincerely,

[Physician Signature]

[Physician Name and Credentials]

Enclosures: [List enclosures, which may include prescribing information, clinical notes/medical records, diagnostic test results, relevant peer-reviewed articles, relevant treatment guidelines, including NCCN Clinical Practice Guidelines in Oncology (NCCN® Guidelines)/ASCO® myelosuppression guidelines, FDA approval letter, scans showing progressive disease, pathology reports].

REFERENCES

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NCCN Clinical Practice Guidelines in Oncology: Hematopoietic Growth Factors, Version 1.2022. Accessed February 16, 2022. To view the most recent version, visit [NCCN.org](https://www.nccn.org).

NCCN Clinical Practice Guidelines in Oncology: Small Cell Lung Cancer, Version 2.2022. Accessed February 16, 2022. To view the most recent version, visit [NCCN.org](https://www.nccn.org).

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