[Date]
[Appeals department]
[Name of health plan]
[Mailing address]

RE: [Patient name]
Policy number: [Policy number]
Treatment requested: YONSA® (abiraterone acetate)

Dear [Medical director],

This letter is sent on behalf of [patient's name] to request an appeal of a denied prior authorization for YONSA® (abiraterone acetate). According to the denial letter, [name of health plan] denied this prior authorization because [reason from denial letter]. I am asking that you reconsider your denial of coverage for YONSA® for the treatment of metastatic CRPC [ICD-10 code] for [patient's name].

Treatment with YONSA® [dose, frequency] (in combination with methylprednisolone) is medically appropriate and necessary for this patient.

[Patent's name] is a [age]-year-old male who was diagnosed with metastatic CRPC on [date]. [Patient's name] has been in my care since [date].

[List any previous therapies/ procedures, response to those interventions, description of the patient's recent symptoms. Use medical judgement and discretion when providing a description of the patient's medical condition.]

Enclosed you will find additional documentation with relevant clinical history for [patient's name], including diagnosis, current condition, and symptoms. Using YONSA® (in combination with methylprednisolone) for my patient is based on [provide a clinical rationale for the use of YONSA® in this clinical case].

Please contact my office by calling [phone number] for any additional information you may require in support of this appeal. I look forward to your timely approval.

Sincerely,
[Physician's signature]
[Physician's name]

Suggested enclosures:
Copy of denial letter
Package insert for YONSA®
Medication records
Clinical records that support the need for YONSA®
Other supporting documentation

PM-US-YON-0273