SAMPLE Letter of Appeal
For Myrbetriq® (mirabegron) extended-release tablets

Date
Payer Name
Payer Address
City, State, ZIP Code
Payer Fax Number

Attn: Payer Representative
Department Name (optional)

Re: Coverage of **Myrbetriq**
Patient's First and Last Name
Policy Number / Patient's ID
Group Number
Patient Date of Birth

Dear Medical or Pharmacy Director:

I am writing to request a review of a denial for ***[patient name]*** for **Myrbetriq**. Your company has denied this claim for the following reason(s).

- **List reason(s)**

Myrbetriq is indicated for the treatment of ***[insert indication description]***. The full prescribing information for **Myrbetriq** can be accessed at www.astellas.com.

[Patient's name]'s medical history and course of treatment are as follows:

- **Describe the patient's history, diagnosis, previous and current treatment regimens and their outcomes.**

Based on ***[patient's name]***'s condition, medical history, and supporting clinical literature, the use of **Myrbetriq** is medically appropriate and necessary.

I respectfully request that you review the additional documentation provided and consider overturning your coverage decision for **Myrbetriq**. I look forward to your reconsideration. If I can provide any additional information, please contact me at ***[insert phone number]*** to ensure the prompt approval of this course of treatment.

Regards,
[Physician Name]

FOR FULL PRESCRIBING INFORMATION SEE WWW.ASTELLAS.COM OR CONTACT ASTELLAS MEDICAL COMMUNICATION AT 1-800-727-7003.

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