[Date]

[City, State Zip]

[Payer Name]

[Payer Address]

Re: [Patient Name]

 [Patient Policy Number]

 [Claim Number]

 [Date(s) of Service]

Dear Sir or Madam:

This letter serves as a request for reconsideration of payment of a denied claim for UDENYCA™(pegfilgrastim-cbqv), a biosimilar administered to [Patient Name] on [Date(s) of Service].

This patient has been under my care for the treatment of [patient diagnosis—insert nonmyeloid diagnosis and myelosuppressive chemotherapy regimen], which increases the patient’s risk of infection from febrile neutropenia. You have indicated that UDENYCA™ is not covered because [reason for denial].

[Briefly describe patient’s symptoms, therapy to date, and any other pertinent information.] UDENYCA™ has decreased the incidence of infection, as manifested by febrile neutropenia, for this patient.

The attached full prescribing information provides the approved clinical information for UDENYCA™. UDENYCA™ has been administered as a medically necessary part of this patient’s treatment.

I would appreciate reconsideration of coverage for the [Date(s) of Service claim(s) for Patient Name].

Please contact me at [Phone Number] if you require additional information.

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 UDENYCA™, medical history, diagnosis, lab results, and treatment plan).]

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