[Date]

[Medical Director]

[Payer Name]

[Address]

[City, State Zip]

Re: [Claim number]

[Patient Name]

[Patient Date of Birth]

[Patient Policy Number]

[Date(s) of Service]

Dear [Medical Director]:

I am writing to appeal the denied claim for CIMERLI™ (ranibizumab-eqrn) injection for my patient, (Patient Name) who has been diagnosed with (insert disease). Attached to this request is the full Prescribing Information for CIMERLI™ and clinical notes regarding this patient’s disease state.

CIMERLI™ is indicated for:

* (Insert indication 1)
* (Insert indication 2)

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

The rationale for treating this patient with is CIMERLI™ [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 look forward to your prompt review of this request.

Please call my office at [Phone Number] if I can provide any 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 CIMERLI™, medical history, diagnosis, lab results, and treatment plan and prescribing information for CIMERLI™)

[NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition. This template is provided for informational purposes. It is not meant to replace a prescriber’s independent medical decision-making.]

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