Yutrepia™ (treprostinil) inhalation powder

SAMPLE LETTER OF APPEAL

Dear Clinician,

On the following page is a sample Letter of Appeal to serve as a template if your patient's health plan has denied coverage of YUTREPIA™ (treprostinil) inhalation powder. This template includes prompts for the information your patient's health plan will expect when evaluating treatment necessity.

This template is a sample of what can be submitted as a comprehensive and impactful appeal so your patient can receive authorization and begin treatment as soon as possible.

Leave blank or enter "N/A" in any field that is not pertinent to your appeal. The letter should be sent on your office letterhead. You can either insert your business logo in the fields provided, or print the letter directly onto your official letterhead. You may also draft and submit a different Letter of Appeal if you prefer.

In addition to the Letter of Appeal, health plans may also require the following supportive evidence:

- Clinical notes documenting a World Health Organization (WHO) Group 1 diagnosis for PAH or WHO Group 3 for PH-ILD.
- Medical records including diagnostic tests
- Clinical studies and relevant guidelines that support the use of YUTREPIA
- YUTREPIA Prescribing Information (PI)

Each health plan may require different information and/or supportive documentation. Providing as much information as possible may help with the health plan's consideration of your request.

The letter template is provided as an example and is intended to be tailored to each prescriber and patient. This letter is not a guarantee of insurance coverage or reimbursement. Coverage and reimbursement may vary significantly by payer, plan, patient and setting of care. It is the sole responsibility of the health care provider to include the proper information and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.

Sincerely,

Your Liquidia Team

Liquidia™

[Date]

[Health Plan Name]
[Health Plan Contact Name]
[Health Plan Address Line 1]
[Health Plan Address Line 2]

Patient Name:
Patient Date of Birth: [mm/dd/yyyy]
Policyholder Name:
(if different from Patient)
Subscriber/Member ID #:
Group ID #:

Re: Appeal for denial of YUTREPIA™ (treprostinil) inhalation powder
Case/Denial #:

Dear [Medical Director Name],

I am writing to request an approval on behalf of my patient, named above, to receive treatment with YUTREPIA™ (treprostinil) inhalation powder. Their health plan has denied coverage of YUTREPIA because:

[Provide denial reason as indicated on explanation of benefits]

INDICATION

YUTREPIA is a prostacyclin mimetic indicated for the treatment of:

- Pulmonary arterial hypertension (PAH; WHO Group 1) to improve exercise ability. Studies establishing effectiveness predominately included patients with NYHA Functional Class III symptoms and etiologies of idiopathic or heritable PAH (56%) or PAH associated with connective tissue diseases (33%).
- Pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) to improve exercise ability. The study establishing effectiveness predominately included patients with etiologies of idiopathic interstitial pneumonia (IIP) (45%) inclusive of idiopathic pulmonary fibrosis (IPF), combined pulmonary fibrosis and emphysema (CPFE) (25%), and WHO Group 3 connective tissue disease (22%).

On the following page, I provide detailed information in support of my request for your consideration. Given the nature of this request, I kindly ask for a timely review and authorization.

If I can provide any additional information, please contact my office at the number below.

Sincerely,
[Prescriber Name]

Phone:
Fax:

Summary of my patient's diagnosis

Patient Name: **Age:** **Gender:**
Diagnosis: [specific diagnosis] **WHO Group:**
ICD-10: **Date of diagnosis:** **NYHA functional class**:

Patient's medical history:

Patient's current condition:

Previous therapies and/or procedures and patient's response:

Current PAH therapies and/or procedures and patient's response:

Tests and results:

- ◯ Right heart catheterization: [RHC result]
- ◯ Echocardiogram: [Echocardiogram result]
- ◯ 6-minute walk test: [6MWD result]
- ◯ High-resolution CT scan: [High-res CT scan result (may be required for PH-ILD)]
- ◯ [Other test] : [Other result]

Rationale for treatment

[example] I have taken great consideration regarding the patient's current condition and prognosis. I believe treatment with YUTREPIA™ (treprostinil) inhalation powder is medically necessary at this time and should be a covered treatment option for this patient.

Supporting documentation:

- ◯ The full Prescribing Information of YUTREPIA™ (treprostinil) inhalation powder. Provided clinical information that played a key part in making my determination that this is the appropriate treatment.

I have also included the following additional documentation to further support my recommendation to treat this patient with YUTREPIA:

- ◯ Diagnostic Test Results
- ◯ Pathology Reports
- ◯ Clinical Notes / Records
- ◯ Medical Scans
- ◯ [Other enclosure 1]
- ◯ [Other enclosure 2]

Prescriber Name: NPI #:

Prescriber Signature:_____
Date:

[OFFICE ADDRESS - IF NOT USING OR NOT ON LETTERHEAD]