**SAMPLE**

**This letter is only intended as a TEMPLATE Letter of Appeal for LIVDELZI® (seladelpar) and may be used or referred to at the discretion of the healthcare provider.**

**INSTRUCTIONS: MUST BE ON HEALTHCARE PROVIDER'S LETTERHEAD AND MUST BE COMPLETED AND SUBMITTED BY THE HEALTHCARE PROVIDER WHEN USED.**

[**Healthcare Provider's Letterhead**]

**[Insert Date]**

**[Medical Director]**
**[Insurance Company Name]**
**[Insurance address]**
**[City, State Zip]**

**RE: Denial of Coverage for LIVDELZI® (seladelpar) for [insert medical diagnosis] Use**

**Patient Name: [Insert Patient Full Name]**
**Insurance ID #: [Insert number]**
**Claim/Document Number: [Insert number from denial letter]**

Dear **[Insert Medical Director's Name]:**

I am writing you on behalf of my patient, **[patient name]**, to request reconsideration (appeal) of your denial of coverage of LIVDELZI® (seladelpar) 10 mg. I have read and acknowledge your denial letter and understand that coverage was denied because **[denial reason from letter]**. Based on my patient's medical condition and medical history, as well as my experience treating patients that have been diagnosed with **[patient diagnosis]**, I feel that LIVDELZI is warranted, appropriate, and medically necessary in this case.

**[Name of patient]** is a [**age**]-year-old patient who was initially considered to be an appropriate candidate for primary biliary cholangitis (PBC) medication on [**mm-dd-yyyy]** by [**Healthcare Provider**] at [**Facility**]. [**Name of patient**] has been in [**treating healthcare provider's name]** care since [**date**]. **[Patient diagnosis and medical history in support of the appeal]**

**[Provide a brief discussion of patient's history and current condition, laboratory results, and supporting documentation as requested by the plan in their denial letter, highlighting those factors leading you to recommend the use of LIVDELZI]**

In summary, this is my **[level of request]** prior authorization/medical exception appeal. A copy of the **[level of denial**] denial letter is included with my medical notes in response to the denial. **[Conclusion statement regarding whether LIVDELZI is appropriate and medically necessary for the patient.]** Please contact me at **[healthcare provider's telephone number]** or via email at **[healthcare provider's email]** if you have any further questions about this matter.

Thank you for your time and consideration in this matter.

Sincerely,

**[Healthcare Provider's Signature]**

**[Physician Name]**
**[contact info]**

**[Enclosures: Chart Notes/diagnostic lab reports, denial letter, medication records, Full Prescribing information, and any other relevant supporting documentation]**

This sample letter is for general information purposes only and is not intended, and does not constitute, legal reimbursement, business, clinical or other advice. Use of this template or the information in this template does not guarantee reimbursement for coverage. Coverage and reimbursement may vary significantly by payer plan, patient, and other factors. The information provided is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional. Responsibility for ensuring the accuracy of information included in any communication between the healthcare provider and the payer remains solely with the healthcare provider.

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