Disclaimer: Use of this template or the information in this template does not guarantee reimbursement for coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional. The completion, accuracy, and submission of this form is the sole responsibility of the healthcare provider.

Cover Page for Letter of Appeal Template for Symbravo®

(meloxicam and rizatriptan)

# The following page is a template that may be customized to use as a letter of appeal for a patient with a denied claim for SYMBRAVO.

# To print a copy of the prescribing information, please visit: <https://www.axsome.com/symbravo-prescribing-information.pdf>

<Date>

**ATTENTION:** <Medical Director Name and/or Medical Review/Appeals>

<Payer/Health Plan Name>

<Payer Address>

**REGARDING:** Denied Claim for Symbravo® (meloxicam and rizatriptan)

**PATIENT NAME:** <Patient Name>

**DATE OF BIRTH:** <Patient Date of Birth>

**POLICY ID NUMBER:** <Patient Policy ID Number>

**PROVIDER ID NUMBER:** <Provider ID Number>

<Optional: Claim rejection number> Dear <Health Plan Contact Name>:

I am writing to appeal the denied claim for SYMBRAVO for my patient, <Patient Name>, for which the reason for denial was <quote the specific reason for denial in denial letter>. As a <board-certified medical specialty> (<NPI>), I have prescribed SYMBRAVO due to my patient being diagnosed with <migraine> <migraine without aura> <migraine with aura> <migraine with typical aura> and consider this choice of treatment as the appropriate option for my patient.

Attached to this request are clinical notes regarding this patient’s disease state and the SYMBRAVO package insert.

SYMBRAVO is indicated for the acute treatment of migraine with or without aura in adults. The following is the medical history of <Patient Name> and the rationale for treatment with SYMBRAVO.

|  |  |
| --- | --- |
| **Date of Diagnosis** | <MM/DD/YY> |
| **Diagnosis** | <ICD-10 code> |
| **Summary of clinical symptoms** | * <Patient’s current condition, including an overview of symptoms and quality of life or functional impairment as applicable>
* <Test information & results>
* <Prognosis without treatment>
 |
| **Previous and current treatment regimens** | <If applicable, include previous and current pharmacologic treatments for migraine, including drug name, dates of use, and reasons for stopping> |

<Restate the denial reason and your clinical rationale for why the denial should be overturned and why SYMBRAVO is medically necessary for this patient.>

Thank you for taking the time to read this letter. I believe treatment with SYMBRAVO is appropriate for this patient. Please feel free to contact me for any additional information you may require. I look forward to your prompt review of this request.

Best regards,

<Physician Signature>

<Physician Name>

<Physician’s NPI>

<Physician Contact Information>

<Phone #>

<Fax #>

# ATTACHMENTS:

* SYMBRAVO package insert/prescribing information
* Patient clinical notes and other relevant supporting documentation

PP-SYM-US-2500076 05/25