Payers may require prior authorization or supporting documentation to process and cover a claim for the requested therapy. A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific Appeal Letter will help to explain the physician's rationale and clinical decision-making in choosing a therapy. The following is a sample Appeal Letter that can be customized based on your patient's medical history and physical examination. Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.

[Insert letterhead with physician's name and address]

Sample Format: Appeal Letter

[Date]
[Payer Name]
[Payer Address]
[Payer City, State, Zip Code]

ATTN: **[Appeals Department]**

RE: **[Patient Name]**
[Policy ID/Group Number]
[Date of Service]

To whom it may concern,

I am writing to request an appeal of the denial for the treatment of **[insert patient's name]** with Recorlev® (levoketoconazole) 150 mg tablets for **[insert diagnosis].**

Recorlev was approved by the US Food and Drug Administration in December 2021. Recorlev is a cortisol synthesis inhibitor that was systematically studied in patients with Cushing's syndrome.

Recorlev is indicated for the treatment of endogenous hypercortisolemia in adult patients with Cushing's syndrome for whom surgery is not an option or has not been curative. Recorlev is not approved for the treatment of fungal infections.

[Insert payer's name] has indicated that the reason for the denial was **[list the reason(s) for the denial]** as per the Denial Letter dated **[insert date of Denial Letter]**. I disagree with this decision and request that this denial be reversed.

In my clinical judgment, treatment with Recorlev is medically necessary because **[list the clinical justification(s) for the use of Recorlev]**.

I have enclosed additional documentation that supports treatment for this patient with Recorlev. I would appreciate your reconsideration of this decision and ask that you reverse it. If you have further questions, please feel free to call me at **[insert telephone number]** to discuss.

Thank you in advance for your immediate attention to this request.

Sincerely,

[Insert physician's name and participating provider number]

[Enclosures (suggested documents): original Prior Authorization Request Form, Denial Letter/EOB, patient medical history, and other supporting documents]