

## QBREXZA Sample Letter of Appeal

### **Sample Letter of Appeal**

*[Physician/Provider letterhead]*

*[Name]*

*[Insurance Company Name]*

*[Address]*

*[City, State ZIP]*

*[Date]*

Member name: *[insert name]*

Member number: *[insert number]*

Group number: *[insert number]*

Claim number: *[insert number]*

To Whom It May Concern:

I am writing to appeal the denial of benefits for the use of Qbrexza™ (glycopyrronium) cloth for *[patient name, member number, group number, claim number]*. Included in this letter of appeal is information on the treatment rationale and medical information confirming Qbrexza as an effective treatment for the diagnosis of primary axillary hyperhidrosis, L74.510.

#### **Treatment History:**

*[Provide information on patient response to past treatments.]*

#### **Summary Statement:**

Qbrexza is an FDA-approved anticholinergic indicated for topical treatment of primary axillary hyperhidrosis in adults and pediatric patients 9 years of age and older. Per the indication and the patient's treatment history with this condition, it is my professional opinion that it is medically necessary for the patient to be treated with Qbrexza. I, therefore, request that your denial be reversed.

Please call my office at *[office phone number]* if I can provide further information or speak with a review board to appeal the decision. I look forward to reaching a resolution to overturn the denial of benefits for the use of Qbrexza for this patient.

Sincerely,

*[Physician's name, signature, and phone number]*

Enclosures: *[Original denial notification copy, Qbrexza PI*

*(<http://pi.dermira.com/QbrexzaPI.pdf>)]*