[PROVIDER LETTERHEAD]

[Date]

[Contact Name]
[Insurance Company]
[Insurance Address]
[Insurance City, State Zip]

Re: **[Patient First Name] [Patient Last Name]**
[Policy Number]
[Group Number]
[Diagnosis]

Appeal Request for HEPLISAV-B™ [Hepatitis B Vaccine (Recombinant), Adjuvanted]

Dear **[Name or 'Insurance Company Payer Department']**:

This letter serves as a formal appeal for reconsideration of coverage for HEPLISAV-B which was originally denied to **[Patient First Name] [Patient Lash Name]**, on **[Date of Service]**. **[Insurance Company Name]** has stated that HEPLISAV-B is not covered because **[Denial Reason]**.

Patient History and Diagnosis

[Patient First Name] is a **[age]**-year-old **[male/female]** who **[continue with patient history and clinical support for medical necessity. Please include relevant risk factors, comorbidities, or occupational necessities]**

It is crucial that **[Insurance Company Name]** provide adequate coverage for HEPLISAV-B for this patient in order to provide important protection against hepatitis B.

On behalf of **[Patient First Name] [Patient Last Name]**, we would appreciate your reconsideration of coverage for HEPLISAV-B. Please call me at **[Primary Treating Site Phone Number]** if I can be of further assistance or you require additional information.

HEPLISAV-B is indicated for prevention against infection caused by all known subtypes of hepatitis B virus in adults 18 years of age and older. Full Prescribing Information and Important Safety Information for HEPLISAV-B can be found at HeplisavB.com.

If you have any questions about HEPLISAV-B, please call the HEPLISAV-B Access Navigator program at 1-84-HEPLISAV (1-844-375-4728), Monday through Friday, 8:00am – 8:00pm ET.

Sincerely,

[Treating Provider Signature]
[Treating Provider First Name] [Treating Provider Last Name], **[Treating Provider Title]**

Enclosures **[suggested]**:
HEPLISAV-B Approval Letter and Package Insert
Supportive Medical Records

.