

[Sample Insurance Physician Appeal Letter #1](#)

*The letter should be tailored to the patient.*

Insurance Company Name

Address

City, State, Zip code

Re: Patient Name  
Date of Birth:  
Appeal Account #:

Dear Insurance Company:

I am appealing the decision and request immunoglobulin be approved for this patient.

**Disease:** Common Variable Immune Deficiency (279.06); severe recurrent infections (listed below), hypothyroidism, allergies

**Clinical History:**

- **Types of infections:**
  - Severe recurrent sinopulmonary infections, but has been on chronic antibiotics for the past 11 months with partial benefit but constant relapse.
  - Sinus x-rays demonstrated clear-cut pansinusitis with opacification, systemic antibiotics together with nasal irrigation gentamicin and an empiric course of Diflucan.
  - Patient also had chronic bronchitis with copious mucus.
- **Hospitalizations & Surgeries:** 2 (Sinus surgery & total thyroid removal)

**Laboratory Studies:**

- After four doses of Prevnar and two doses of the pneumococcal vaccine, patient did not respond to any of the pneumococcal serotypes. In addition, he responded to only three out of seven of the Prevnar (protein behaving antigens). Therefore, using the well accepted, classic definition of poor antibody response to less than 50% (in this case zero), patient falls into the severe phenotype.
- Despite repeated infections, patient's quantitative immunoglobulins are low.

**Patient Fulfills the criteria for IVIG on the following:**

- ✓ Repeated, chronic, poorly responsive respiratory disease to aggressive antibiotic and other anti-infectious measures.
- ✓ Patient has objective data indicating persistent infection with chronic inflammation, pansinusitis with opacification despite aggressive systemic antibiotics, antifungal and antibiotic irrigation
- ✓ Patient has clear-cut, well documented laboratory studies indicating immunodeficiency.

**Therefore, IVIG is warranted.**

Should you have any questions, I would request a peer review by members of the \*Primary Immunodeficiency Committee of the American Academy of Allergy, Asthma and Immunology that contributed to "Use of intravenous immunoglobulin in human disease".

With very best wishes.

Sincerely,

John Smith, M.D.

[List credentials](#)

Enclosures

\* [References](#)

[Appropriate records](#)

[Sample Insurance Physician Appeal Letter #2](#)

*The letter below was successful in overturning a denial of IVIG. Patient was approved for 1 year.  
The letter should be tailored to the patient.*

Insurance Company Name

Address

City, State, Zip code

Re: Patient Name

Date of Birth:

Appeal Account #:

To Whom This May Concern:

I am appealing the decision that immunoglobulin is "not generally accepted and is medically unnecessary".

1. The patient has a clearly defined immunologic disease (see attached reference): [Selective Antibody Deficiency \(Boyle, et al\)\\*](#).
2. The patient has absolute non-responsiveness to [pneumococcal /tetanus/diphtheria](#) vaccine(s).
3. The patient has well documented, over xx episodes of antibiotic usage (see attached).

[Include specific, tailored to the patient, statements:](#)

After four doses of Prevnar and two doses of the 23-valent pneumococcal vaccine (Pneumovax), patient did not respond to any of the pneumococcal serotypes. In addition, he responded to only three out of seven of the Prevnar (protein behaving antigens). Therefore, using the well accepted, classic definition of poor antibody response to less than 50% (in this case zero), patient falls into the severe phenotype as described by Sorenson and others (see attached).

In addition to the appropriate clinical documentation of recalcitrant infections, attached is the latest pneumococcal response titers as well as several documents including the Academy Diagnostic Vaccine Working Group Final Draft on Vaccination Response, the Australian article by Boyle on Selective Antibody Deficiency (classic paper), the Sorensen paper on poor Antibody Response in Immune Deficient Children and my correspondence with the Immune Deficiency Foundation on the use of IVIG in appropriate patients as well as documentation. Therefore, we felt that immunoglobulin should be used.

Should you have any questions, I would request a peer review by either Dr. E. Richard Stiehm or Dr. Richards Sorensen at the Louisiana State University School of medicine.

With very best wishes.

Sincerely,

John Smith, M.D.

[List credentials](#)

Enclosures

\* [References](#)

[Appropriate records](#)

Sample Insurance Physician Appeal Letter #3

*The letter below was successful in overturning 2 appeals that were previously rejected. Patient was approved for 2 years. The letter should be tailored to the patient.*

Insurance Company Name

Address

City, State, Zip code

Re: **EXPEDITED APPEAL**

Patient Name

Date of Birth:

Appeal Account #:

To Whom This May Concern:

I am requesting an expedited appeal for denial to use gammaglobulin infusions (subcutaneous) for Jane Doe. She has had an excellent evaluation by a very fine clinical immunologist (physician name & credentials). This youngster fulfills all of the standard requirements for the use of IVIG: 1. She has a defined immunologic disorder (selective antibody deficiency) – with no response to conjugated pneumococcal vaccine. In addition, she has poor to no response to conjugated pneumococcal vaccine (Prevnar). This was after four Prevnars and two pneumococcal vaccines. Further, she received four tetanus vaccinations and had no functional, measurable antibodies. 2. She has documented laboratory abnormalities (see attached #1). She has recalcitrant, documented chronic significant infections. Her infections are well documented in the medical records (see attached notes, as well as my consultation, #2) and, she was hospitalized last fall for pneumonia and despite prophylactic antibiotics has had breakthrough infections. She has also seen an ear, nose, & throat surgeon (Surgeon's name). She also has constitutional symptoms with febrile and failure to thrive.

I am attaching my consult, relevant notes from her current doctor (Name), the appropriate laboratory studies as well as the following: 1. Article by R.J. Boyle et al from Australia (Clin Exper Immunol 2006: 146:486-492), & the excellent article by Ricardo Sorensen et al (Pediatr Infect Dis J 1998: 17:685-91).

Should there be any questions, please do not hesitate to let me know. If an outside reviewer is required, I would suggest Dr. E. Richard Stiehm (UCLA), Dr. Ricardo Sorensen (LSU), Dr. Rebecca Buckley (Duke) or Dr. Mark Ballow (SUNY-Buffalo). These are considered the world's experts in this disease. I appreciate your kind support these many years and I do hope you will rule favorably on this appeal as the youngster is quite ill and is not thriving.

With very best wishes.

Sincerely,

John Smith, M.D.

[List credentials](#)

Enclosures

\* *References*

*Appropriate records*

Sample Insurance Physician Appeal Letter #4

*The letter below was successful in overturning a denial of IVIG. Patient was approved for 1 year.*

*The letter should be tailored to the patient.*

Insurance Company Name

Address

City, State, Zip code

Re: Patient Name

Date of Birth:

Appeal Account #:

To Whom This May Concern:

Thank you for your kind letter and for your review by a physician. I would like to appeal this denial with the following provisos: 1. That the patient stop smoking. 2. That a short trial of IVIG (3 month) be implemented, monitoring the following criteria: a. decreased number of pneumonia/bronchitis. b. Decreased breakthrough requiring IV or oral antibiotics. c. Decreased febrile episodes. d. Decreased symptoms of bacterial sinusitis.

The criteria for using IVIG in primary immunodeficiency requires the following: 1. Evidence for significant hypogammaglobulinemia. 2. Significant and frequent episodes for sinopulmonary infections, otitis and, on occasion, infectious gastroenteritis or other systemic infections. 3. Impaired response to non-conjugated polysaccharide antigens and/or protein antigens. 4. Failure to respond to aggressive anti-infectious and anti-inflammatory agents. 5. Discounting other potential causes for chronic sinopulmonary infections e.g. alpha-1 antitrypsin disease, cigarette smoking, etc.

I believe the patient fulfills the above criteria; however, what makes his case a little more complicated is that he has several factors which put him in the gray zone: 1. He smokes. 2. He works in an environment which has a number of inhalant irritants. 3. Mediocre function to polysaccharide antigens.

The issue of response to polysaccharide antigens has been a longstanding one. Dr. Richard Wasserman & Dr. Roger Kobayashi published a symposium approximately 20 years ago looking at what constitutes an appropriate response. The most recent consortium has suggested that a normal response would mean protective and/or a four-fold rise in 75% of the serotypes. The patient responded to slightly less than this criteria (poor response in 5 out of 14). Clinically, he has had multiple visits to the family doctor, allergists and other specialties and has had evidence of pneumonia by chest x-ray.

These cases are difficult for immunologists, recognizing the extraordinarily high cost of health care in the United States, the very high costs of treating chronically ill patients (in this case, primary immunodeficiency with a very expensive treatment for a very long time). I sympathize to both the patient and their treating doctors as well as the insurance companies and the enormous burden it places on our Nation.

Nevertheless, if the above criteria I have outlined in the opening statements of this letter can be fulfilled, I believe a trial of IVIG is warranted in this patient. I would request that an immunologist review this case Dr. E. Richard Stiehm (UCLA), Dr. Rebecca Buckley (Duke) or Dr. Mark Ballou (SUNY-Buffalo). They are very well respected immunologists who also see patients and therefore, may be able to give a balanced view. With very best wishes.

Sincerely,

John Smith, M.D.

[List credentials](#)

Enclosures

*\* References & Appropriate records*

## \* References

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- Wasserman RL, Sorensen RU. Evaluating children with respiratory tract infections: the role of immunization with bacterial polysaccharide vaccine. *Pediatr Infect Dis J*. 1999 Feb;18(2):157-63. Review.
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