**Sample Letter of Appeal for an Additional Tube of ANZUPGO® (delgocitinib) Cream**

Use this sample letter when a request for an additional tube of ANZUPGO cream is denied. Modify as needed based on your clinical judgment and remember to address the health plan’s specific requirements. Use of the information in this letter does not guarantee that coverage for ANZUPGO will be granted, and it is not intended to be a substitute for, or an influence on, the independent medical judgment of the healthcare provider.

The coding information in this sample letter is provided for informational purposes only and is subject to change. The ICD-10-CM codes listed may not apply to all patients or to all health plans; it is the responsibility of the healthcare provider to select the appropriate ICD-10-CM code(s) and submit claims that accurately reflect the services and products furnished to a specific patient.

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[Physician letterhead]

[Date]

Attn: [Insert health plan contact name] Patient name: [Insert patient name]

[Insert health plan name] DOB: [Insert patient’s date of birth]

[Insert health plan mailing address] [Insert health plan mailing address] Policy number: [Insert subscriber policy number] Group number: [Insert subscriber group number]

Claim number: [Insert patient claim number]

**Re:** Appeal Request for Additional Tube of ANZUPGO® (delgocitinib) Cream

Dear [insert Medical Director name/name of health plan contact],

I am writing on behalf of my patient, [insert patient name] to request approval for a monthly total of
60 g of ANZUPGO (two 30 g tubes) for the treatment of their Chronic Hand Eczema (CHE) (ICD-10-CM code[s]: [Insert ICD-10-CM code(s). **Example codes include:** **Allergic contact dermatitis**: L23.0-L23.7, L23.81, L23.89, **Atopic dermatitis:** L20.89, L20.9, **Irritant contact dermatitis:** L24.0-L24.7, L24.81, L24.89, L24.A1, L24.A2, L24.A9, L24.B1-L24.B3, **Other and unspecified dermatitis:** L30.1, L30.8, L30.9]). My patient was denied a refill request on [date of denial] for the following reason:

* [Insert denial reason (e.g., quantity limit exceeded, refill requested too soon)]

Please note that ANZUPGO is supplied in both 30 and 60 g tubes, and while the 30 g tube is the only option currently available for dispense, ANZUPGO was approved by the US Food and Drug Administration in both packages.

I am requesting this approval of 60 g per month for at least 4 months, in line with the timeframe of the ANZUPGO clinical trials, to provide my patient with the opportunity to continue to see and maintain an improvement in their CHE.

My patient is responding well to treatment with ANZUPGO for CHE, and I do not want their treatment regimen to be interrupted because they no longer have product to apply to the affected area(s) of the hands and wrists.

Please see a summary of my patient’s clinical history below, which provides additional relevant information:

[Include patient’s clinical history, improvement in quality of life (QoL) measures (if available), and other evidence supporting the use of 60 g of ANZUPGO per month for your patient.]

As you consider this request, please also refer to the enclosed materials. If you require additional information, please contact me at [insert phone number]. I look forward to receiving your timely response and coverage determination.

Sincerely,

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 (Signature)

[Insert physician’s name]

[Insert NPI #]

[Insert practice address]

[Insert practice phone number]

* **Enclosures:** [ANZUPGO Prescribing Information, clinical trial publication(s), clinical notes/medical records, documentation of age-appropriate vaccinations as recommended by current immunization guidelines, including herpes zoster vaccinations, peer-reviewed literature, photos documenting improvement of patient’s condition (indicate dates each photo was taken, if possible), copy of the patient’s health plan or prescription card (front and back)]

**Reference:** ANZUPGO Prescribing Information. LEO Pharma.

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