

<Date>
<Insurance Company Name>
<Insurance Company Address>
<Insurance Company City>, <State> <Zip>

Re: <Patient Name>
Policy Number: <Policy Number>
Group Number: <Group Number>
Subscriber: <Policy Holder Name>

Dear <Insurance Carrier/Medical Director/Claims Representative>:

You have indicated that MACUGEN[®] (pegaptanib sodium injection) is not covered by <Insurance Company Name> because of <denial reason>. This correspondence serves as a request for reconsideration of payment for <Patient Name>'s treatment with MACUGEN.

Product Description

MACUGEN is an established therapy approved by the FDA for the treatment of patients with neovascular (wet) age-related macular degeneration (AMD). MACUGEN 0.3 mg is administered once every 6 weeks by intravitreal injection into the eye to be treated. Pegaptanib is an aptamer, a pegylated modified oligonucleotide, which adopts a 3-dimensional conformation that enables it to bind to extracellular VEGF. Under in vitro testing conditions, pegaptanib binds to the major pathological VEGF isoform, extracellular VEGF165, thereby inhibiting VEGF165 binding to its VEGF receptors.

Patient's Medical History and Treatment Rationale

<Patient Name> is being treated by <Physician Name>, <Title>, and was diagnosed with neovascular (wet) AMD. Since this diagnosis, <Patient Name> <outline previous therapy and outcomes>.

MACUGEN is a necessary part of this patient's treatment, and I would appreciate your reconsideration of coverage for this medication. Without this treatment the patient's vision may continue to decline, potentially leading to blindness. Please contact me at <Physician Phone> if you require additional information.

Sincerely,
[Physician Signature]

<Physician Name>, <Title>