

This form is required for each of your patient’s insurances and will serve as proof that the patient’s insurance company will not cover the prescribed Valcyte® (valganciclovir hydrochloride) therapy. Please complete all applicable sections below. Completion of this form does not guarantee coverage in GATCF.

**My office received an initial claim denial or Prior Authorization (PA) denial.**

Date of initial claim or PA denial: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Reason for initial claim or PA denial: (check one box)**

- |  |   |
|--|---|
| <input type="checkbox"/> Administrative / billing / clerical Error | <input type="checkbox"/> Labs / diagnostic testing/ biopsy        |
| <input type="checkbox"/> Appeal deadline exceeded                  | <input type="checkbox"/> No prior authorization (PA) obtained     |
| <input type="checkbox"/> Diagnosis off-label                       | <input type="checkbox"/> Not considered medically necessary       |
| <input type="checkbox"/> Line of therapy                           | <input type="checkbox"/> Not seen by a specialist                 |
| <input type="checkbox"/> Dosing                                    | <input type="checkbox"/> Patient demographics                     |
| <input type="checkbox"/> Drug combination                          | <input type="checkbox"/> Physician and/or facility out of network |
| <input type="checkbox"/> Exclusion – diagnosis or drug             | <input type="checkbox"/> Step therapy                             |
| <input type="checkbox"/> Experimental / investigational            | <input type="checkbox"/> Untimely filing                          |
| <input type="checkbox"/> Other: _____                              |   |

**My office submitted a first-level appeal on:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**My office received a first-level appeal denial on:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Reason for first-level appeal: (check one box)**

- |  |   |
|--|---|
| <input type="checkbox"/> Administrative / billing / clerical error | <input type="checkbox"/> Labs / diagnostic testing/ biopsy        |
| <input type="checkbox"/> Appeal deadline exceeded                  | <input type="checkbox"/> No prior authorization (PA) obtained     |
| <input type="checkbox"/> Diagnosis off-label                       | <input type="checkbox"/> Not considered medically necessary       |
| <input type="checkbox"/> Line of therapy                           | <input type="checkbox"/> Not seen by a specialist                 |
| <input type="checkbox"/> Dosing                                    | <input type="checkbox"/> Patient demographics                     |
| <input type="checkbox"/> Drug combination                          | <input type="checkbox"/> Physician and/or facility out of network |
| <input type="checkbox"/> Exclusion – diagnosis or drug             | <input type="checkbox"/> Step therapy                             |
| <input type="checkbox"/> Experimental / investigational            | <input type="checkbox"/> Untimely filing                          |
| <input type="checkbox"/> Other: _____                              |   |

**My office received a peer-to-peer denial.**

Date of review: \_\_\_\_/\_\_\_\_/\_\_\_\_

Denial reason: \_\_\_\_\_

**My patient has met the daily/yearly cap for insurance coverage.**

Date cap was met: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date cap reset: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please complete, sign and date the following statement (Required field (\*))**

Office Contact Signature\*: \_\_\_\_\_ Date\*: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Insurance Company Name: \_\_\_\_\_

Print Patient’s First and Last Name: \_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CERTIFICATION:** By signing above, I certify this form is an accurate representation of my patient’s insurance status and his/her insurance company’s refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements. I know GATCF could ask me for a copy of the patient’s insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient’s denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.