PALSONIFY™ (paltusotine) Sample Letter of Appeal Template

This sample letter of appeal template is provided as a guidance tool to support your patient undergoing treatment with PALSONIFY. As a healthcare provider, you are expected to evaluate your patient's specific medical needs and update the content accordingly based on your clinical judgment. Crinetics does not assume liability for any outcomes resulting from the use of this sample letter of appeal template.

Crinetics® Pharmaceuticals

Once-Daily Oral Palsonify™ (paltusotine) tablets

US-PAL-2500078-1 09/2025

Sample Letter of Appeal for PALSONIFY™ (paltusotine)

[Physician's letterhead]

[Date]
[Health plan contact]
[Health plan name]
[Health plan street address]
[Health plan city, state ZIP]

RE: Appeal for Denial of PALSONIFY™ (paltusotine) Coverage

[Insured patient name]
Date of birth: [patient date of birth]
Policy number: [Policy #]
Group number: [Group #]
Case number: [Case # (if known)]

To whom it may concern,

My name is [name, medical specialty (NPI)], and I am writing to formally appeal the denial of coverage for PALSONIFY for my patient, [Patient Full Name], who has been under my care for the treatment of acromegaly (ICD-10: E22.0) since [Date].

According to the denial letter, dated [date of denial letter], coverage for PALSONIFY was denied due to [reason(s) for denial stated in denial letter]. I request reconsideration of this decision, as PALSONIFY is medically necessary and appropriate for the management of my patient's condition based on [his/her] documented clinical history, current disease state, and prior treatment. Please be aware that denying my patient coverage may put [him/her] at risk for increased complications and/or lead to a worse condition.

[Patient name] is [a/an age]-year-old [male/female] patient who has been diagnosed with acromegaly [ICD-10-CM diagnosis code, (eg, E22.0)] since [date, year]. [Describe patient's current condition, including lab values (eg, IGF-1 level) and evidence of patient's symptoms, such as recent decline over time and its impact on quality of life.]

My current treatment plan for [patient name] includes [current acromegaly therapy] at [dosage and frequency]. [Patient name] has been on this treatment plan since [date]. My patient has previously tried [list any past treatment(s), start/stop dates, and

reason(s) for discontinuing or contraindications/ineligibility for specific treatments]. [If applicable to the patient's history, include any increased frequency of injections and/or combination therapy.]

[Restate the denial reason(s), your clinical rationale for why the denial should be overturned, and why PALSONIFY is appropriate and medically necessary for this patient (eg, reason for denial noted was that the patient has not tried generic octreotide injection. This is not an appropriate option for this patient given [reasoning such as elevated laboratory results or contraindications]).]

Based on my clinical judgment, I request that you overturn the denial and approve coverage of PALSONIFY for [patient full name]. I have enclosed additional documentation to further support the medical justification for PALSONIFY approval. My office can be contacted at [phone number] or [email address] if additional information is required.

Thank you for your time and reconsideration of your decision.

Sincerely,
[Physician name, medical specialty, NPI]
[Physician address]
[Physician phone number]
[Physician fax number]

Enclosures [suggested]:
[Relevant patient medical records, including applicable laboratory results]
[Letter of Medical Necessity]
[PALSONIFY Prescribing Information]

Reference: ICD10Data.com. Acromegaly and pituitary gigantism. Accessed July 18, 2025. https://www.icd10data.com/ICD10CM/Codes/E00-E89/E20-E35/E22-/E22.0