**Template Letters | Sildenafil Approval**

***This letter is only an example.*** *Please edit the letter to suit your needs and replace* ***[bold]*** *sections with the appropriate information.*

**[PH CENTER LETTERHEAD]**

**[TODAY’S DATE]**

**[INSURANCE COMPANY]**

**[ADDRESS]**

**[PHONE/FAX]**

Re: **[PATIENT NAME, DOB]**

 **[MEMBER ID]**

To Whom It May Concern:

I write concerning **[PATIENT NAME]** prescription coverage benefits. Please consider coverage for sildenafil (Revatio) **[DOSE]** three times per day. **[PATIENT NAME]** has been followed by **[PH PROGRAM NAME]** since **[DATE]** for his/her diagnosis of pulmonary arterial hypertension (PH) related to **[INSERT ASSOCIATED WITH OR DELETE]**. **[PATIENT NAME]** has World Health Organization (WHO) functional class **[INSERT]** symptoms, including **[LIST IN DETAIL]**.

**[LIST PATIENT HISTORY INCLUDING COMPLICATIONS TO PREVIOUS THERAPY, FAILURES TO FDA APPROVED DOSES, RATIONAL FOR PRESCRIBING SILDENAFIL AS FIRST LINE THERAPY AND BE SPECIFIC TO THIS PATIENT.]**

Other PH treatments including continuous infusions of epoprostenol (Flolan and Veletri), treprostinil (Remodulin, Tyvaso, and Orenitram), or inhaled iloprost (Ventavis) treatments would have significantly higher costs along with risks of complications. Other oral FDA approved treatments for PH include, bosentan (Tracleer), ambrisentan (Letairis), macitentan (Opsumit), tadalafil (Adcirca), riociguat (Adempas), and selexipag (Uptravi) which would be significantly more costly than sildenafil (Revatio) at the requested **DOSAGE [INSERT $ AMOUNT BASED ON DOSE REQUESTED]** per month. To further reduce the cost of sildenafil treatment sildenafil (Viagra) could be considered at **[INSERT DOSE]** three times a day. This would provide the medically indicated dose at a substantial cost savings.

It is medically indicated for **[PATIENT NAME]** to be considered for this requested dose of sildenafil (Revatio) due to **[LIST SPECIFICS TO THIS PATIENT: WORSENING SYMPTOMS PROGRESSION, ECHO RESULTS, PA PRESSURES, 6MW DISTANCES]**.

We have attached additional evidence **[ATTACH EVIDENCE OR DELETE]** demonstrating the importance of sildenafil treatment. Thank you for your time and consideration for reimbursement of sildenafil (Revatio) **[DOSE]** three times daily for **[PATIENT NAME]** treatment of pulmonary hypertension. Please contact our program for further questions or information about this request.

Sincerely,

**[SIGNATURE]**

**[INSERT NAMES OF MD AND NURSE COORDINATOR]**

**[LIST SPECIALTY]**

**[ADDRESS]**

**[PHONE NUMBER] [FAX NUMBER]**