Sample Letter of Appeal
Patient to remain on current drug therapy

[Date]

[Physician Name]
[Health Care Practice Name]
[Health Care Practice Address]
[City, State, Zip Code]

[Insurance Name and DOB]
[Patient Name]
[Patient Insurance ID#]
[Denial Reference Number]

Dear Medical or Pharmacy Director:

This letter of [List level of appeal] appeal is in regards to your coverage policy that does not provide coverage for [Drug name] for the treatment of [Diagnosis]. I have reviewed your drug coverage policy and feel that the denial for [Drug name] be overturned and authorized as it is medically necessary to treat their diagnosis of [Diagnosis and ICD-10 code]. I am requesting to be approved to continue on [Drug name].

[Patient name] has been treated since [Date] with [Drug name]. [The patient has had the following experience on the drug:]

Included with this letter of medical necessity for the denial to be overturned and for [Patient name] to be approved to continue with treatment of [Drug name] are relevant medical history notes, supporting clinical trials information, letter of medical necessity and FDA approval data.

[Summarize the reason for the patient to remain on [Drug name] and list potential adverse health outcomes that could arise from the patient discontinuing drug utilization].

Sincerely,

X _____

[Physician name]
[Phone number]