Sample Letter of Appeal
Patient to convert to a new drug therapy

[Date]

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

[Patient Name]
[Patient Address]
[Patient Insurance ID#]
[Denial Reference Number]

Dear Medical or Pharmacy Director:

This letter of [Insert level of appeal] is a formal appeal of your coverage decision for [Drug name]. I request that [Insurance name] denial decision be reversed and coverage approved for [Drug name] as it is medically necessary to treat the diagnosis of [Diagnosis and ICD-10 code]. The appropriate treatment at this time is to discontinue [Drug name] and to prescribe [Drug name].

I have been treated by [Doctor name] since [Date] to manage [Diagnosis and ICD-10 Code]. I have been on [Drug name] since [Date].

The rationale for prescribing [Drug name] include:

- [Reason(s) supporting changing to new drug prescription]

Included with this letter of appeal to be approved to change to [Drug name] are relevant supporting medical documentation including a letter of medical necessity, clinical trial information, and FDA approval information. [Summarize reasons for the patient to convert to utilizing the recommended new drug]. Please feel free to contact my physician or myself if we can provide further information or coordinate a peer to peer review for your approval decision to overturn your denial decision and authorize [Drug name].

Sincerely,

X _____ X _____

[Patient name or authorized representative]
[Phone number]

[Physician name]
[Phone number]