[Date]
[Medical Director]
[Insurance Company Name]
[Address]
[City, State ZIP]
Re: *Patient Name:*
Patient Date of Birth:
Policy Number:
Claim Number:

Dear *[Medical Director]*:

Please accept this letter as a formal request for reconsideration of the denial in the above-referenced claim. As documented below, treating *[patient name]* with Protopic® (tacrolimus) Ointment is reasonable and medically necessary and should be covered by *[plan]*. Please find enclosed the package insert and peer-reviewed literature that support the use of Protopic for *[patient name]*.

[This is where you should provide a brief summary of patient history, including:
• Description of patient's condition and date of diagnosis
• Circumstances surrounding care
• Previous therapies and any complications
• Standard of care for treatment
• Any other relevant information]

Based on *[patient name]*'s condition, medical history, and supporting clinical literature, treatment with Protopic is medically appropriate and necessary.

I respectfully request that you review the additional documentation provided and reevaluate your coverage of Protopic for *[patient name]*. I look forward to your reconsideration. If I can provide any additional information, please contact me at *[insert practice phone number]*.

Regards,

[Provider]

Encl.

[Enclose additional documents as specifically required by payer in appeal procedures or supportive of use. May include:
• FDA-approved Prescribing Information
• Copy of the original claim
• Copy of the denial notification from the payer
• Patient's complete medical history
• Relevant peer-reviewed articles supporting the use of Protopic
• Designated payer-specific appeal form
• Coverage guidance from other payers in alignment with use in question]