

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Subject: Appeal for Coverage of Xtandi

Dear [Insurance Company Representative's Name or "To Whom It May Concern"],

I am writing to formally appeal the denial of coverage for the medication Xtandi (enzalutamide) for my treatment. My policy number is [Your Policy Number], and the claim number associated with this request is [Claim Number].

[Provide a brief explanation of your medical condition, including diagnosis, treatment history, and why Xtandi is necessary for your health.]

The denial letter dated [Denial Letter Date] indicated that coverage was denied due to [reason for denial]. However, I would like to provide additional information and medical documentation that supports the necessity of treating my condition with Xtandi.

[Include a summary of relevant medical information, such as physician's notes, treatment plans, and any supporting literature or clinical guidelines that advocate for the use of Xtandi in your situation.]

Given the evidence and my physician's recommendation, I urge you to reconsider the decision and approve coverage for Xtandi. This medication is critical to my health and well-being.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,

[Your Name]

[Your Signature (if sending a hard copy)]