

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

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

Subject: Appeal for Coverage of Xtandi

Dear [Recipient Name],

I am writing to formally appeal the denial of coverage for Xtandi, a medication my healthcare provider prescribed for my [specific condition] as detailed in my medical records.

[Optional: Briefly explain your medical history and why Xtandi is necessary for your treatment.]

According to the documentation provided by my physician, [Doctor's Name], Xtandi is essential for [explain the medical necessity and any previous treatments that have been tried]. Without this treatment, my health may significantly deteriorate.

Enclosed are the following documents to support my appeal:

1. Letter of medical necessity from Dr. [Doctor's Name]
2. Relevant medical records
3. [Any additional documents]

I kindly request that you reconsider my case and approve coverage for Xtandi. Thank you for your attention to this important matter.

Sincerely,

[Your Name]  
[Your Policy Number]