[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient's Name]
[Recipient's Title]
[Healthcare Provider/Insurance Company Name]
[Address]
[City, State, Zip Code]
Subject: Xtandi Eligibility Verification
Dear [Recipient's Name],
I am writing to request verification of eligibility for the medication Xtandi (enzalutamide) for my patient, [Patient's Name], who has been diagnosed with [Patient's Condition].
Please find the pertinent details below:
- **Patient Name:** [Patient's Full Name]
- **Date of Birth:** [Patient's DOB]
- **Insurance Provider:** [Insurance Company Name]
- **Policy Number:** [Policy Number]
- **Diagnosis:** [Specific Diagnosis]
- **Previous Treatments:** [List of Previous Treatments]
- **Prescribing Physician:** [Physician's Name, Contact Information]
We would appreciate your prompt assistance in determining coverage for Xtandi as it is a critical component of the treatment plan for [Patient's Name]. Please let us know if additional information is required.
Thank you for your attention to this matter.
Sincerely,
[Your Name]
[Your Title/Position]
[Your Organization/Practice Name]