[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 Medication

Dear [Insurance Company Appeals Department/Specific Contact Name],

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 denial was communicated to me on [Date of Denial].

[Insert a brief description of your medical condition and why Xtandi is medically necessary. Include any relevant details such as previous treatments, progression of the disease, and your physician's recommendation.]

According to my physician, [Doctor's Name], MD, [add specific supporting information about Xtandi, including clinical benefits, FDA approval, and how it is the most appropriate treatment for your condition]. Enclosed are documents that support the necessity of this treatment, including [list any attached documents: medical records, physician letters, clinical guidelines, etc.].

I urge you to reconsider this decision and approve coverage for Xtandi. This medication is critical for my health and well-being, and I believe it is essential to my treatment.

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)]

Enclosures: [List of documents attached]