LETTER OF MEDICAL NECESSITY APPEAL TEMPLATE FOR NON-MEDICAL SWITCHING

[Healthcare Provider Name]
[Title]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

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

Re: Request for Continuing Coverage of (Medication Name) for Treatment of Alopecia Areata

To Whom It May Concern:

I am writing to formally request that [Insurance Company Name] continue to provide coverage for (current medication name) for my patient, [Patient's Full Name], who has been successfully taking (current medication name) for the treatment of alopecia areata.

Medical Necessity of (Current Medication Name) for Treating Alopecia Areata

As you are aware, alopecia areata is an autoimmune disease that causes unpredictable and often distressing hair loss, and it can significantly impact the mental and emotional well-being of those affected. After careful evaluation and treatment consideration, (current medication name) was prescribed as an appropriate therapeutic option for my patient and approved and covered by (insurance provider) for (amount of time).

(Current medication name) is an FDA-approved, effective treatment for managing alopecia areata. Many studies (provide as references at end) have demonstrated (current medication's name) ability to promote hair regrowth in patients with moderate to severe alopecia areata, which lead to our shared decision to start (patient name) on (current medication's name).

Include length of time on current medication and describe treatment success. Be sure to include other therapies tried/failed before starting current medication. Include photos of your regrowth, if available.

If applicable: The denial is based on the premise that (patient) has not yet failed (insurance company's preferred drug). (Current drug) has already proven to be effective for the patient demonstrating significant clinical improvement. There are no data demonstrating that (current medication name) and (insurance company's preferred drug) are interchangeable. (Insurance company's preferred drug,) which has a unique pharmacokinetic and pharmacodynamic profile, may not provide the same therapeutic benefit and could possibly reverse the progress (patient) has made. The risk of regression or treatment failure is far too great to warrant a nonmedical switch.

In addition, given the distressing nature of this condition, the psychological impact of visible hair loss, and the failure of prior treatment options, (current medication name) represents a necessary and appropriate option for achieving optimal therapeutic outcomes. Switching to a new therapeutic agent for nonmedical reasons would cause further distress and uncertainty. Given patient's positive response and stability on (current drug,) it is medically necessary for him/her to continue this treatment to maintain progress and further recovery.

In light of the substantial clinical evidence supporting (current medication's name) efficacy and safety profile for (patient name), I respectfully request that [Insurance Company Name] continue to provide coverage for (current medication name).

Thank you for your time and consideration of this request. Please do not hesitate to contact me if you require any further information or clarification.

Sincerely,

[Healthcare Provider Name]
[Title]
[Contact Information]