Medication Coverage Denial - Detailed Medical Justification

Subject: Appeal for Denied Prescription Coverage - [Medication Name]

Dear Pharmacy Benefits Manager,

I am appealing the denial of coverage for [Medication Name] prescribed by my physician, Dr. [Name], on [Date]. The denial letter indicated that [Generic Alternative/Step Therapy Required/Not Covered].

I have a documented history of adverse reactions and treatment failures with the following alternatives:

- [Alternative 1]: [Specific adverse reaction or reason for failure]
- [Alternative 2]: [Specific adverse reaction or reason for failure]
- [Alternative 3]: [Specific adverse reaction or reason for failure]

My physician has provided detailed medical records documenting these failures and explaining why [Medication Name] is the only viable treatment option for my condition. This medication has proven effective in managing my [Condition] with minimal side effects.

Denying coverage for this medication forces me to either pay $[Amount] out of pocket monthly or risk serious health deterioration. My policy includes prescription coverage, and I have met all deductibles and co-payment requirements.

I have attached a letter of medical necessity from Dr. [Name], pharmacy records showing previous medication trials, and relevant medical literature supporting the use of this medication for my specific condition.

I request an expedited review and approval of this medication coverage.

Respectfully,

[Your Name]

[Member ID]

[Date]

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