[Date]
[Insurance Company Name]
[Attn: Prior Authorization Department / Appeals Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Gabapentin
Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Case ID: [Case ID Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request coverage for Gabapentin for the treatment of Chronic Pelvic Pain Syndrome (CPPS) (ICD-10 Code: [Insert Code, e.g., N53.8]). Although the FDA has not specifically labeled Gabapentin for CPPS, it is a standard-of-care, evidence-based treatment for neuropathic pain components associated with this condition.

Clinical History:
The patient has been diagnosed with CPPS and has been suffering from chronic symptoms for [Duration of Time]. The patient's symptoms include [List symptoms, e.g., persistent pelvic pressure, neuropathic burning, and muscular dysfunction], which significantly impact their daily functioning and quality of life.

Previous Failed Therapies:
The patient has attempted and failed the following treatments or has contraindications to them:

- [Treatment Name, e.g., NSAIDs]: [Reason for failure/Duration]
- [Treatment Name, e.g., Physical Therapy]: [Reason for failure/Duration]
- [Treatment Name, e.g., Muscle Relaxants]: [Reason for failure/Duration]

Medical Justification:
Gabapentin is medically necessary for this patient to manage the neuropathic pain signaling involved in CPPS. Peer-reviewed clinical literature supports the use of gabapentinoids in reducing central sensitization and chronic pelvic discomfort when traditional therapies are insufficient. Given the patient's clinical presentation, I believe Gabapentin is the most appropriate pharmacological intervention at this time.

I request that you approve coverage for Gabapentin as prescribed. Please contact my office at [Phone Number] if you require further clinical documentation or have additional questions.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Phone Number]