Date: [Date]

To: [Insurance Company Name]
Attention: [Prior Authorization/Appeals Department]
Address: [Insurance Company Address]
Fax/Phone: [Fax or Phone Number]

Re: Letter of Medical Necessity for Low-Dose Naltrexone (LDN)
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Insurance Policy ID]
Group Number: [Group Number]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request coverage for Low-Dose Naltrexone (LDN) for the management of Fibromyalgia (ICD-10: M79.7). Although Naltrexone is FDA-approved at higher doses for opioid and alcohol dependence, its use at a low dose (typically 1.5mg to 4.5mg) is a clinically recognized off-label treatment for chronic pain and neuroinflammation associated with fibromyalgia.

Clinical History:
The patient has been diagnosed with Fibromyalgia since [Year]. Their symptoms include [list symptoms, e.g., chronic widespread pain, sleep disturbance, and cognitive dysfunction]. These symptoms significantly impact the patient's daily functioning and quality of life.

Previous Treatments:
The patient has attempted and failed the following standard therapies due to lack of efficacy or intolerable side effects:

- [Drug Name, e.g., Duloxetine]: [Reason for failure]
- [Drug Name, e.g., Pregabalin]: [Reason for failure]
- [Drug Name, e.g., Milnacipran]: [Reason for failure]
- [Other Modalities, e.g., Physical Therapy]: [Results]

Rationale for LDN:
Peer-reviewed clinical studies have demonstrated that LDN acts as a glial cell inhibitor and modulates the immune system, reducing the pro-inflammatory cytokines that contribute to central sensitization in fibromyalgia patients. Given the patient's history and the failure of conventional FDA-approved medications, LDN is medically necessary to manage their condition and prevent further functional decline.

I request that you grant an exception for this off-label use and provide coverage for [Patient Name]'s LDN prescription. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

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