[Date]

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

RE: Letter of Medical Necessity for Guanfacine (Off-Label Use)
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for Guanfacine [Extended-Release/Immediate-Release] for my patient, [Patient Name], for the treatment of Severe Anxiety Disorder (ICD-10 code: [Insert Code, e.g., F41.1]). While I acknowledge that this medication is currently FDA-approved for ADHD, its use is medically necessary for this patient's specific presentation of anxiety and physiological over-arousal.

Clinical History and Diagnosis:
[Patient Name] has been diagnosed with Severe Anxiety Disorder characterized by [list symptoms, e.g., extreme hypervigilance, emotional dysregulation, physical symptoms of autonomic arousal, or sleep disturbance]. The patient's symptoms significantly impair their ability to function in [school/home/social] environments.

Previous Failed Treatments:
The patient has previously tried and failed the following standard-of-care treatments due to lack of efficacy or intolerable side effects:
1. [Medication Name, e.g., Sertraline]: [Reason for failure]
2. [Medication Name, e.g., Fluoxetine]: [Reason for failure]
3. [Therapy Type, e.g., CBT]: [Outcome]

Rationale for Guanfacine:
Guanfacine is an alpha-2A adrenergic receptor agonist. In this clinical case, it is being prescribed to address the patient's sympathetic nervous system overactivity. There is growing clinical evidence supporting the use of alpha-agonists in pediatric patients who are refractory to SSRIs or who experience heightened "fight or flight" responses that exacerbate their anxiety disorder.

Treatment Plan:
I intend to prescribe [Dosage, e.g., 1mg] daily to stabilize the patient's symptoms. I will monitor the patient closely for blood pressure, heart rate, and clinical response.

In summary, Guanfacine is a critical component of [Patient Name]'s treatment plan. Please approve this request for coverage. If you require further information, please contact my office at [Phone Number].

Sincerely,

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