[Date]

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

RE: Letter of Medical Necessity for Oral Minoxidil

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to request coverage for oral Minoxidil for the treatment of Androgenetic Alopecia (ICD-10 L64.9) for my patient, [Patient Name].

While oral Minoxidil is FDA-approved for hypertension, its use is widely recognized in clinical dermatology as a standard-of-care, off-label treatment for hair loss when topical therapies are ineffective or poorly tolerated. [Patient Name] has been diagnosed with progressive Androgenetic Alopecia, which is causing significant psychological distress and impairment to their quality of life.

Clinical History and Rationale:

- The patient has failed to respond to or has had an adverse reaction to topical Minoxidil [mention specific reactions if applicable, e.g., contact dermatitis].
- The patient has tried and failed other conventional treatments, such as [mention Finasteride or other therapies, if applicable].
- Oral Minoxidil at a low dose ([X] mg daily) is medically necessary for this patient to prevent further permanent follicular miniaturization and hair loss.

Peer-reviewed literature supports the safety and efficacy of low-dose oral Minoxidil for this indication. Given the patient's clinical history, I believe this treatment is the most appropriate next step in their care.

Please contact my office at [Phone Number] if you require further documentation or clinical notes.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[NPI Number]
[Practice Name]