[Date]

[Health Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Member Name: [Patient Name]

Member ID Number: [ID Number]

Claim/Reference Number: [Denial Reference Number]

Medication Requested: [Brand Name Medication]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for **[Brand Name Medication]** prescribed for **[Patient Name]** for the treatment of Diabetes Mellitus. This medication is medically necessary for the patient's health and stability.

The denial was based on **[Reason for denial stated in letter]**. However, the formulary alternatives are not appropriate for this patient due to the following reasons:

- **Previous Treatment Failure:** The patient has tried and failed the following preferred medications: [List generic/formulary meds tried and dates].
- **Contraindications:** The patient cannot take [Formulary Medication] because of [List medical reason or allergy].
- **Clinical Stability:** The patient is currently stable on [Brand Name Medication], and switching to a different medication poses a significant risk of hyperglycemia, hypoglycemia, or loss of glycemic control.

Enclosed are medical records, recent A1C laboratory results, and a letter of medical necessity from the prescribing physician to support this request.

We request that you overturn the previous decision and approve coverage for **[Brand Name Medication]** immediately. Please provide a written response regarding this appeal within [Number of days] days.

Sincerely,

[Your Name/Physician Name]
[Phone Number]
[Provider NPI Number]