[Your name]
[Your address]
[Your city, state, ZIP]
[Your phone number]
[Tax ID#]

[Date]

[Name of Rx Plan]
[Address of Rx Plan]

Re: Request for Reconsideration of DAYVIGO™ (lemborexant) tablets (CIV) use for [patient name]
Member ID:
Group or Medicare #:
Rx Bin:
Claim or Explanation of Benefit #:

To Whom It May Concern:

I am writing on behalf of my patient, [patient's name], to appeal your denial of coverage for use of DAYVIGO™ (lemborexant). The above claim was denied as [not medically necessary, not covered on the formulary, etc.]. We are requesting a redetermination of the denial of coverage for DAYVIGO™.

[Outline the patient's history, diagnosis, and treatment plan. Provide rationale for DAYVIGO™ treatment.]

For the reason provided above, I believe that DAYVIGO™ should be covered by [payor name] for this patient. Enclosed please find relevant documentation to support this request for redetermination.

Kindly contact me at [phone number] if you need any additional information or would like to discuss this further. Thank you for your prompt attention and consideration of this matter, and for your anticipated approval for DAYVIGO™ in the treatment of [patient's name].

Sincerely,

[Physician Name]

Enclosures [suggested]: supportive medical records