Date: [Date]

RE: Summary of Previously Failed Generic Formulary Alternatives

Patient Name: [Patient First and Last Name]
Patient Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Requested Medication: [Brand Name Medication]

To [Insurance Company Name] Pharmacy Benefit Manager,

This letter serves to document the clinical reasons why the generic formulary alternatives for [Patient Name] have been unsuccessful. The patient requires the requested brand-name medication due to the failure of the following generic trials:

Generic Alternative Tried	Dates of Trial	Reason for Failure (Side Effects or Lack of Efficacy)
[Generic Name 1]	[Start Date] to [End Date]	[Detailed explanation of clinical failure]
[Generic Name 2]	[Start Date] to [End Date]	[Detailed explanation of clinical failure]
[Generic Name 3]	[Start Date] to [End Date]	[Detailed explanation of clinical failure]

Based on the documented failures above, it is my professional medical opinion that the generic alternatives are not suitable for this patient. The requested medication, [Brand Name Medication], is medically necessary for the treatment of [Diagnosis/Condition].

Please review this summary and approve the coverage for the requested medication to ensure continuity of care.

Sincerely,

[Physician Name]
[NPI Number]
[Clinic/Practice Name]
[Phone Number]