[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Your Phone Number]
[Your Member ID Number]

[Date]

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

RE: Formulary Exception Appeal for [Name of Medication]

To Whom It May Concern:

I am writing to formally appeal the denial of coverage for [Name of Medication]. I am requesting a formulary exception because this medication is medically necessary for the treatment of my condition, [Name of Condition].

My prescribing physician, [Doctor's Name], has determined that the drugs currently on your formulary are not appropriate for my treatment for the following reasons:

- [Reason 1: e.g., I have already tried the preferred medications (List them) and they were ineffective.]
- [Reason 2: e.g., I experienced adverse side effects from the preferred medications.]
- [Reason 3: e.g., The preferred medication is contraindicated due to other health conditions or drug interactions.]

Attached to this letter is a supporting statement from my physician, along with relevant medical records and documentation of my treatment history. These documents confirm that [Name of Medication] is the most effective and safe option for my specific health needs.

I request that you review this appeal promptly and grant an exception to provide coverage for this prescription. Please notify me and my physician of your decision in writing within the required timeframe.

Thank you for your time and consideration.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from [Doctor's Name]

Medical Records/Lab Results
Previous Pharmacy Records