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

[Date]

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

RE: Formulary Exception Appeal
Patient Name: [Patient Name]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for the following medication: [Name of Prescription Drug]. My physician has prescribed this medication as a matter of medical necessity for the treatment of [Name of Condition].

The denial stated that this medication is not on the plan's formulary. However, I am requesting a formulary exception for the following reasons:

- **Failure of Formulary Alternatives:** I have previously tried the following formulary-approved medications: [List Drug A and Drug B]. These treatments were unsuccessful because [Explain side effects or lack of efficacy].
- **Contraindications:** The alternative medications on the formulary are contraindicated for me because [Explain medical reason or drug interactions].
- **Clinical Stability:** I have been stable on [Name of Requested Drug] for [Length of Time], and switching to a different medication poses a significant risk to my health and progress.

Attached to this letter is a statement of medical necessity from my treating physician, [Physician Name], as well as relevant clinical documentation supporting this request.

I request that you review this appeal and grant an exception to cover [Name of Prescription Drug] at the appropriate tier level. I look forward to your written response within the required timeframe.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
- Letter from Physician
- Medical Records/Lab Results
- Previous Denial Notice