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

[Date]

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

RE: Appeal of Prescription Coverage Denial

Patient Name: [Patient Name]
Date of Birth: [DOB]
Claim/Reference Number: [Reference Number from Denial Letter]
Prescription Name: [Name of Medication]

To Whom It May Concern,

I am writing to formally appeal the denial of a prior authorization for [Medication Name]. This request is for a formulary exception based on medical necessity.

My physician, [Doctor's Name], has prescribed this medication to treat [Medical Condition]. I have previously tried the following formulary alternatives, which were unsuccessful:

- [Alternative Medication 1]: [Reason for failure/side effects]
- [Alternative Medication 2]: [Reason for failure/side effects]

Because the preferred medications on the formulary have proven ineffective or caused adverse reactions, it is medically necessary for me to receive [Medication Name]. Clinical documentation and a letter of support from my provider are attached to this appeal.

I request that you review this case and grant a formulary exception so that I may continue my prescribed treatment plan. I look forward to your response within the timeframe required by law.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List attached documents, such as doctor's letter or medical records]