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

[Date]

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

RE: Continuity of Care Appeal for Prescription Formulary Exception

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 based on the necessity of continuity of care.

I have been stabilized on this medication for [Number of Months/Years] to treat [Medical Condition]. My healthcare provider, [Doctor's Name], has determined that switching to a formulary alternative would pose a significant risk to my health, potentially causing [Side Effects/Relapse/Adverse Reactions].

Attached is a letter of medical necessity from my physician outlining why the preferred drugs on the formulary are not appropriate for my clinical situation. Because this medication is essential to maintaining my current health status, I request that you grant an exception and continue coverage at the previous benefit level.

I look forward to your timely response regarding this urgent medical matter. Thank you for your assistance.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from [Doctor's Name]
Recent Medical Records/Prescription History