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

[Date]

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

RE: Formal Appeal for Prescription Formulary Exception
Patient Name: [Patient Name]
Date of Birth: [DOB]
Claim/Reference Number: [Reference Number if applicable]
Prescribed Medication: [Medication Name]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Medication Name], which was prescribed by my physician, [Doctor's Name], for the treatment of [Medical Condition]. It is my understanding that this request was denied because the medication is being used off-label or is not currently on the formulary for this specific diagnosis.

My physician has determined that [Medication Name] is medically necessary for my condition. Standard formulary treatments have been considered or attempted and were found to be [ineffective / contraindicated / poorly tolerated] in my specific case. Specifically, I have previously tried:

- [Name of Drug 1] - Result: [Brief Reason for Failure]
- [Name of Drug 2] - Result: [Brief Reason for Failure]

Although this medication is being used off-label, there is significant clinical evidence and peer-reviewed medical literature supporting its efficacy for [Medical Condition]. I have attached [mention any attachments: clinical studies, a letter of medical necessity from your doctor, or medical records] to support this request.

Without access to this medication, I am at risk for [mention potential health risks or complications]. Therefore, I request an expedited review and a formulary exception to ensure I receive the necessary treatment to manage my condition effectively.

Thank you for your prompt attention to this matter. I look forward to your response within [Number] days.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from Dr. [Doctor's Name]
Relevant Medical Records
Clinical Study Reprints/Citations