Date: [Date]

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

RE: Prescription Formulary Exception Appeal

Patient Name: [Patient Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

Dear Appeals Committee,

I am writing to formally appeal the denial of a formulary exception for the medication **[Name of Requested Medication]**. This request is based on documented adverse reactions and medical necessity.

I have previously attempted to use the formulary-preferred alternative(s), **[Name of Formulary Drug(s)]**. However, use of these preferred medications resulted in the following adverse reaction(s):

- [Describe specific side effect or allergic reaction]
- [Describe severity and duration of the reaction]
- [Note if medical intervention was required due to the reaction]

Because of these severe adverse reactions, the formulary drugs are clinically contraindicated for my treatment. Continuing treatment with the preferred alternatives poses a significant risk to my health and safety.

My physician, **[Doctor's Name]**, has determined that **[Name of Requested Medication]** is the only safe and effective treatment for my condition, **[Diagnosis]**. Attached to this letter, you will find clinical documentation and a statement of medical necessity from my healthcare provider supporting this appeal.

I request that you reconsider your decision and grant an exception to cover **[Name of Requested Medication]** at the preferred benefit level. Please provide a written response regarding this appeal within [Number of days, e.g., 72 hours for urgent or 30 days for standard] days.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Phone Number]
[Your Email Address]

Enclosures:
- Letter of Medical Necessity from [Doctor's Name]
- Medical records documenting adverse reactions
- Copy of original denial letter