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

[Date]

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

**RE: Appeal for Prescription Dosage Adjustment (Formulary Exception)**

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

To the Appeals Department,

I am writing to formally appeal the denial of coverage for a dosage adjustment of [Medication Name]. My physician has prescribed a dosage of [Requested Dosage], which currently exceeds the standard formulary quantity limits or dosage guidelines set by [Insurance Company Name].

I am requesting a formulary exception for this specific dosage based on medical necessity. My prescribing physician, Dr. [Physician Name], has determined that the standard formulary dosage is ineffective for my condition. Below is a summary of the clinical justification:

- **Diagnosis:** [State your condition]
- **Treatment History:** I have previously tried the standard dosage of [Standard Dosage] from [Date] to [Date], but it failed to manage my symptoms adequately.
- **Clinical Rationale:** [Briefly state why the higher/different dose is needed, e.g., metabolic rate, severity of symptoms, or failure of lower doses].

Without this specific dosage adjustment, I am at risk for [mention potential health risks or complications]. Please find the enclosed supporting documentation and a Letter of Medical Necessity from my doctor.

I request that you review this appeal and provide a written response within [Number of days, e.g., 72 hours for urgent or 30 days for standard] regarding your decision. If you require further information, please contact my physician's office at [Physician Phone Number].

Thank you for your time and consideration.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: [List any attachments, such as Doctor's Letter or Lab Results]