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 Full Name]
Date of Birth: [Patient DOB]
Member ID Number: [Member ID]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for the brand-name medication **[Name of Brand-Name Drug]**. I am requesting a formulary exception to allow for the coverage of this specific brand-name version of the medication instead of the generic or preferred alternative(s).

My physician, **Dr. [Doctor Name]**, has determined that the brand-name medication is medically necessary for the treatment of **[Condition Name]**. The formulary-preferred medication(s) **[Name of Generic or Alternative]** are not suitable for my treatment due to the following reasons:

- **Clinical Failure:** I have previously trialed the generic/preferred alternative from [Date] to [Date] and it failed to effectively control my symptoms.
- **Adverse Reaction:** I experienced a documented adverse reaction or allergy to the inactive ingredients (fillers/dyes) found in the generic version that are not present in the brand-name medication.
- **Therapeutic Necessity:** Due to the narrow therapeutic index of this drug, my physician has determined that switching from the brand-name to a generic would pose a significant health risk or cause clinical instability.

Attached to this letter, please find clinical documentation, including [mention attachments like medical records, lab results, or a letter of medical necessity from your doctor], which supports this request.

I request that you review this appeal and grant an exception for the coverage of **[Name of Brand-Name Drug]** at the preferred tier level. Should you require additional information, please contact my physician's office at [Doctor's Phone Number] or me at [Your Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Letter of Medical Necessity from Physician
Pharmacy records/History of adverse reactions
Clinical trial results or relevant medical literature