[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]

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

RE: Formulary Exception Appeal for [Medication Name]
Member Name: [Member Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Medication Name], which has been prescribed by my physician, [Doctor's Name], for the management of my chronic condition, [Name of Chronic Illness].

I am requesting a formulary exception because this specific medication is medically necessary for my stability and long-term health. My physician has determined that the preferred medications on your formulary are not appropriate for my treatment for the following reasons:

- [Reason 1: e.g., Previous failure of formulary drugs A and B]
- [Reason 2: e.g., Contraindications or potential adverse reactions to formulary alternatives]
- [Reason 3: e.g., Clinical stability already achieved on current medication]

Enclosed is a letter of medical necessity from my doctor, as well as [mention any other documents, such as lab results or clinical notes], which further details my diagnosis and treatment history. [Medication Name] is the most effective treatment to prevent [mention complications or worsening of the chronic illness].

Please review this appeal and the attached medical documentation immediately. I look forward to your timely response regarding this exception.

Sincerely,

[Your Signature]
[Your Printed Name]