[Your Name]
[Your Address]
[Your Phone Number]
[Your Member ID Number]

[Date]

[Appeals Department Name]
[Health Insurance Company Name]
[Appeals Department Address]

RE: Second Level Formal Appeal for Prescription Formulary Exception
Patient Name: [Patient Name]
Claim/Reference Number: [Reference Number from First Denial]
Medication Requested: [Drug Name and Dosage]

To the Appeals Committee,

I am writing to formally request a Second Level Review of the denial for a formulary exception regarding [Drug Name]. This medication was prescribed by my physician, [Doctor's Name], to treat [Medical Condition].

My first level appeal was denied on [Date of First Denial] for the following reason: [Reason cited in the first denial letter]. I am appealing this decision because the formulary-preferred alternatives are medically inappropriate for my specific case.

The following points support the necessity of this medication:

- **Failed Alternatives:** I have previously tried the following formulary medications: [List names of failed drugs]. These were unsuccessful because [explain side effects or lack of efficacy].
- **Medical Contraindications:** Other formulary options, such as [Drug Name], cannot be used because [explain medical reason or drug interaction].
- **Clinical Stability:** I have been stable on [Requested Drug Name] for [Time Period], and switching medications would pose a significant risk to my health.

Attached to this letter is a statement from [Doctor's Name] and relevant clinical documentation supporting the medical necessity of this specific treatment.

I request that you overturn the previous decision and grant an exception for this life-sustaining medication. I look forward to your response within the timeframe required by my plan's guidelines.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures:
Physician Letter of Support
Medical Records/Lab Results
First Level Denial Letter Copy