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

[Date]

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

RE: Formal Appeal for Prescription Coverage Exception

Patient Name: [Your Name]
Member ID Number: [Your Member ID]
Group Number: [Your Group Number]
Claim/Reference Number: [Reference Number from Denial Letter]

Dear Appeals Committee,

I am writing to formally appeal the denial of coverage for the medication [Name of Medication], prescribed by my physician, [Physician Name]. This medication was denied because it is currently not on the formulary/list of covered medications.

I am requesting a formulary exception for the following reasons:

- **Medical Necessity:** My physician has determined that this specific medication is medically necessary to treat my condition, [Name of Condition].
- **Previous Treatment Failure:** I have already tried the following formulary alternatives: [List alternative drugs tried]. These were unsuccessful because [explain side effects or lack of efficacy].
- **Contraindications:** I cannot take the standard formulary alternatives because [explain why, e.g., allergy or interaction with other medications].

Attached is a letter of medical necessity from my doctor, as well as relevant medical records supporting this request. [Name of Medication] is essential for my health and stability, and switching to a different medication would pose a significant risk to my wellbeing.

Please review this appeal and provide a written decision within [number of days, e.g., 30 days or 72 hours if urgent]. If you require any additional information, please contact me or my physician's office at [Physician Phone Number].

Thank you for your time and consideration.

Sincerely,

[Your Signature]

[Your Printed Name]