[Physician Date of Letter]

[Payer Name]
[Payer Address]
[City, State, Zip Code]

RE: Exception/Prior Authorization Request for [Patient Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern:

I am writing to formally request coverage for [Name of Specialized Medication] for my patient, [Patient Name]. This medication is medically necessary for the treatment of [Diagnosis/Condition Name] (ICD-10 Code: [Code]).

Clinical History:
[Patient Name] has been under my care since [Date]. The patient presents with [List symptoms and severity]. Current clinical findings include [List relevant lab results or diagnostic findings].

Previous Treatments:
The patient has previously tried and failed the following formulary alternatives or standard therapies:

- [Medication A]: [Dates used]. Reason for discontinuation: [Side effects/Lack of efficacy].
- [Medication B]: [Dates used]. Reason for discontinuation: [Side effects/Lack of efficacy].

Medical Justification:
[Name of Specialized Medication] is required because [Explain why this specific drug is needed over others, citing unique mechanism of action or specific patient contraindications to other drugs]. Clinical data suggests that this treatment is the most appropriate course of action to prevent [List potential complications or hospitalizations].

Based on the patient's history and the specialized nature of this condition, I request an immediate approval for this prescription.

Please contact my office at [Phone Number] if you require additional documentation or clinical notes.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[NPI Number]
[Practice Name]