

**Date:** [Date]

**To:** [Insurance Company Name]

**Attn:** [Prior Authorization/Medical Review Department]

**Fax:** [Fax Number]

**Address:** [Insurance Company Address]

**RE: Exception Request for Quantity Limit**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Member ID:** [Member ID Number]

**Group Number:** [Group Number]

**Case Reference Number:** [If applicable]

To Whom It May Concern,

I am writing to formally request a quantity limit exception for [Name of Specialized Formula] for my patient, [Patient Name]. The current quantity limit allowed by the plan is insufficient to meet the patient's medically necessary nutritional requirements.

**Clinical Diagnosis:** [Enter Diagnosis, e.g., FPIES, Severe Cow's Milk Allergy, Short Bowel Syndrome, Failure to Thrive]

**Medical Necessity:**

The patient requires [Number] ounces/kilocalories per day to sustain adequate growth and hydration. Based on this requirement, the patient needs [Total Number of Cans/Containers] per month. The current limit of [Current Limit] covers only [Percentage]% of the patient's daily caloric intake, putting them at risk for malnutrition, dehydration, and [mention other risks like hospitalization or developmental delay].

**Previous Interventions:**

The following standard formulas or lower quantities have been trialed and failed:

- [Formula Name/Quantity]: [Result/Reason for Failure]

- [Formula Name/Quantity]: [Result/Reason for Failure]

This specialized formula is the primary source of nutrition for this patient. Any reduction in the prescribed amount will directly impact the patient's health and clinical outcome. I request that you approve an exception to the quantity limit for a period of [Duration, e.g., 12 months].

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]

[Clinic/Hospital Name]