

[Date]

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

RE: Quantity Limit Exception Request

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Medication Name: [Medication Name and Strength]

To Whom It May Concern,

I am writing to formally request a quantity limit exception for the immunosuppressant medication listed above for [Patient Name]. As the patient's treating physician, I have determined that the standard quantity limit allowed by your plan is insufficient for the successful management of the patient's medical condition.

Diagnosis: [Specific Medical Condition/Organ Transplant Type]
Requested Dosage: [Specific Dosage and Frequency]
Requested Quantity: [Total Amount per 30 days]

Clinical Justification:

The patient requires this specific quantity because [Reason: e.g., standard dosing is ineffective, weight-based dosing requirements, or prevention of graft-versus-host disease/organ rejection]. To maintain therapeutic blood levels and prevent life-threatening complications or irreversible organ damage, the patient must adhere to this specific high-dose regimen.

Failure to provide the requested quantity puts the patient at significant risk for [List Risks: e.g., acute rejection, systemic inflammation, or hospitalization].

I request that you approve this exception to ensure the patient's continued health and stability. Please contact my office at [Phone Number] if you require additional clinical documentation or lab results.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Clinic Name]