

[Date]

[Health Plan Name]

[Appeals/Pharmacy Department Address]

[City, State, Zip Code]

RE: Tier Exception / Tier Reduction Request

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID Number: [Member ID]

Prescription Medication: [Medication Name]

To Whom It May Concern,

I am writing to formally request a tier reduction for [Medication Name] on behalf of my patient, [Patient Name]. This medication is currently placed on Tier [Current Tier Number] of your formulary. I am requesting that it be covered at the cost-sharing level of the lower tier, Tier [Requested Tier Number], as this medication is medically necessary for the patient's condition.

Clinical Justification:

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. I have determined that the preferred medications on the lower tiers are not clinically appropriate for this patient because:

- [Reason 1: e.g., Failure of lower-tier alternative (List drugs and dates)]
- [Reason 2: e.g., Contraindication to lower-tier alternative]
- [Reason 3: e.g., Adverse reactions experienced with lower-tier alternative]

Due to the patient's specific medical history and the severity of their condition, [Medication Name] is the most effective treatment option. The current cost-sharing tier poses a significant financial barrier that may result in non-adherence and subsequent clinical decline.

I request that you grant this tier exception to ensure the patient has affordable access to their required therapy. Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]

[Practice Name]