

URGENT: EXPEDITED FORMULARY TIER EXCEPTION REQUEST

Date: [Insert Date]

TO: [Insurance Company Name]

Attn: Pharmacy Appeals/Prior Authorization Department

Fax Number: [Insert Fax Number]

RE: Patient Name: [Patient Name]

Date of Birth: [Patient DOB]

Member ID: [Patient Member ID]

Group Number: [Patient Group Number]

Provider Information:

Physician Name: [Physician Name]

NPI Number: [NPI Number]

Phone Number: [Phone Number]

Fax Number: [Phone Number]

Medication Requested: [Drug Name, Strength, and Frequency]

Requested Tier Change: From [Current Tier] to [Requested Tier]

Medical Necessity Statement:

I am writing to formally request an expedited formulary tier reduction for the medication listed above. This request is based on medical necessity and the clinical requirements of the patient.

Clinical Justification:

- **Diagnosis:** [Insert Diagnosis/ICD-10 Code]
- **Failed Medications:** The patient has previously tried and failed the following preferred/lower-tier alternatives: [List Medications and reasons for failure, e.g., adverse reaction, lack of efficacy].
- **Contraindications:** Lower-tier alternatives are contraindicated for this patient because: [Provide specific medical reasons].
- **Urgency:** An expedited 24-hour review is required because a delay in treatment would seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Physician Signature: _____

Attachments: [Relevant Lab Results / Clinical Notes]