

Date: [Date]

To: [Health Insurance Company Name]

Attn: Pharmacy Benefit Manager / Appeals Department

Fax: [Fax Number]

Address: [Insurance Company Address]

RE: Formulary Tier Reduction Exception Request

Patient Name: [Patient Name]

Date of Birth: [Patient DOB]

Member ID: [Insurance Member ID]

Policy Number: [Policy Number]

Prescribed Medication: [Drug Name and Dosage]

To Whom It May Concern,

I am writing to formally request a formulary tier reduction exception for the medication listed above for my pediatric patient, [Patient Name]. This medication is currently placed on Tier [Current Tier Number]. I am requesting that it be covered at the Tier [Requested Lower Tier Number] cost-sharing level.

Clinical Diagnosis: [Diagnosis Name and ICD-10 Code]

Medical Necessity:

The requested medication is medically necessary for this patient because:

- [Reason 1: e.g., Patient failed lower-tier alternatives such as (Drug A, Drug B)]
- [Reason 2: e.g., Pediatric-specific formulation (liquid/chewable) is only available for this drug]
- [Reason 3: e.g., Adverse reactions or contraindications to formulary alternatives]

The alternatives on the lower tiers are clinically inappropriate for this pediatric patient due to [Specific Clinical Reason]. Without access to this specific medication at an affordable cost tier, the patient is at risk for [Clinical Risks/Complications].

Please review this request for a tier exception to ensure the patient receives the necessary treatment without undue financial hardship. Should you require additional documentation or clinical notes, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Provider Name], MD/DO

NPI Number: [NPI Number]

Practice Name: [Clinic/Hospital Name]

Phone: [Phone Number]