Date: [Date]

Attn: Pharmacy Utilization Management / Appeals Department
Health Plan Name: [Health Plan Name]
Fax Number: [Fax Number]

RE: Formulary Tier Reduction Exception Request

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Prescription Medication: [Drug Name and Dosage]

Dear Medical Director,

I am writing to formally request a tier reduction exception for the medication listed above. This medication is medically necessary for the long-term management of my patient's chronic condition: [Name of Chronic Condition].

The medication is currently placed on Tier [Current Tier Number]. I am requesting that it be covered at the [Lower Tier Number] cost-sharing level for the following clinical reasons:

- **Treatment Failure:** The patient has previously tried and failed the following lower-tier formulary alternatives: [Alternative 1] and [Alternative 2]. These medications were ineffective or caused adverse reactions including [List Side Effects].
- **Clinical Necessity:** Based on the patient's medical history, other lower-tier drugs are contraindicated because [Provide Clinical Reason].
- **Condition Stability:** The patient is currently stable on this medication. A change in therapy poses a significant risk of [Relapse/Hospitalization/Disease Progression].

Due to the chronic nature of this condition, the patient requires this specific therapy indefinitely. Providing a tier reduction will ensure medication adherence and prevent more costly medical interventions in the future.

Attached please find supporting medical documentation and clinical notes. Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Physician Name]
[NPI Number]
[Clinic Name]