Date: [Date]

To: [Insurance Company Name]
Attention: Pharmacy and Therapeutics Committee / Appeals Department
Address: [Insurance Company Address]
Fax Number: [Insurance Fax Number]

RE: Specialty Medication Tier Reduction Request

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

Dear Medical Director,

I am writing to formally request a formulary tier exception for [Medication Name]. This medication is currently placed on Tier [Current Tier Number]. I am requesting that it be moved to Tier [Lower Tier Number] for this patient due to medical necessity and financial hardship.

Clinical Justification:
The patient has been diagnosed with [Diagnosis/ICD-10 Code]. I have determined that [Medication Name] is the most appropriate treatment for this patient's condition because:

- The patient has tried and failed the following preferred formulary alternatives: [List Drugs and Dates].
- Preferred alternatives are contraindicated for this patient due to: [List Contraindications/Side Effects].
- The patient is currently stable on this medication, and a change in therapy poses a significant risk to their health.

Financial Impact:
The current cost-sharing requirements for Tier [Current Tier Number] create a significant financial barrier that threatens the patient's treatment adherence. Reducing the tier will ensure the patient can maintain the prescribed dosing schedule necessary to manage their chronic condition.

Supporting clinical documentation and relevant lab results are attached to this request. Thank you for your time and consideration of this exception.

Sincerely,

[Physician Name]
[Medical Practice Name]
[Phone Number]
[NPI Number]