

**Date:** [Date]

**To:** [Insurance Company Name]

**Department:** [Appeals/Pharmacy Department]

**Address:** [Insurance Company Address]

**Fax Number:** [Insurance Fax Number]

**RE: Request for Formulary Tier Reduction (Member/Patient)**

**Patient Name:** [Patient Name]

**Date of Birth:** [Patient DOB]

**Member ID:** [Member ID Number]

**Group Number:** [Group Number]

To Whom It May Concern,

I am writing to formally request a formulary tier reduction for the medication [**Requested Medication Name**]. This request is based on the patient's documented adverse reactions to the lower-tier alternatives currently listed on your formulary.

The patient has previously attempted treatment with the following formulary-preferred medication(s):

- [**Preferred Drug Name 1**]: The patient experienced [Description of Adverse Reaction/Side Effect] on [Dates of Trial].
- [**Preferred Drug Name 2**]: The patient experienced [Description of Adverse Reaction/Side Effect] on [Dates of Trial].

The adverse reactions experienced were severe enough to warrant immediate discontinuation of the lower-tier drugs and represent a significant risk to the patient's health and safety. Consequently, these alternatives are medically contraindicated.

[**Requested Medication Name**] is medically necessary for this patient as it provides the required therapeutic benefit without the specific side effects mentioned above. I am requesting that this medication be covered at the [Preferred Brand/Lower Tier] cost-sharing level for this patient.

Attached please find supporting clinical documentation, including office notes and records of the adverse reactions.

Thank you for your prompt attention to this matter. Please notify me of your decision via fax or mail.

Sincerely,

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone Number]  
[Fax Number]