Date: [Date]

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

RE: Request for Tier Reduction / Formulary Exception
Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]

Dear Medical Director,

I am writing to formally request a tier reduction for the medication **[Medication Name]**, which has been prescribed to **[Patient Name]** for the treatment of **[Specific Diagnosis/ICD-10 Code]**. This medication is currently listed on Tier [Current Tier Number] of your formulary, and I am requesting it be covered at the Tier [Requested Lower Tier Number] cost-sharing level.

Clinical Justification:

The patient has a history of [Duration] treating this condition. We have attempted treatment with the following formulary alternatives, which were unsuccessful:

- **[Alternative Drug 1]:** [Reason for failure: e.g., lack of efficacy, specific side effect]
- **[Alternative Drug 2]:** [Reason for failure: e.g., contraindication, adverse reaction]

Medical Necessity:

The requested medication, [Medication Name], is medically necessary for this patient because [provide specific reason, e.g., unique mechanism of action, stabilized on this dose for years, previous hospitalization when off this specific med]. Requiring the patient to pay the higher tier co-pay creates a financial barrier that risks medication non-adherence, which could lead to clinical relapse, emergency department visits, or inpatient psychiatric hospitalization.

I request that you grant this tier reduction to ensure the patient can maintain access to this essential psychiatric treatment. Should you require additional documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO/NP]
[NPI Number]
[Practice Name]
[Phone Number]