Date: [Date]

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

RE: Formulary Tier Exception / Tier Reduction Request

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Policy/Group Number: [Group Number]

Prescribed Medication: [Drug Name, Dosage, and Frequency]
Diagnosis: [Specific Type of Cancer and ICD-10 Code]

To Whom It May Concern,

I am writing to formally request a formulary tier reduction for the medication listed above. This oncology treatment is medically necessary for my patient, and I am requesting that it be covered at a lower cost-sharing tier (e.g., Preferred Brand tier instead of Non-Preferred/Specialty tier) due to clinical necessity.

Clinical Justification:

- **Formulary Alternatives:** I have reviewed the lower-tier medications on your formulary, including [Name lower-tier alternatives].
- **Contraindications:** These alternatives are clinically inappropriate for this patient because: [List reasons: e.g., drug interactions, specific biomarkers, or previous failure of those drugs].
- **Standard of Care:** The prescribed treatment is considered the gold standard for this patient's specific pathology and stage of cancer according to NCCN guidelines.

Failure to provide this specific medication at an affordable tier may lead to treatment non-adherence, disease progression, or adverse clinical outcomes. This medication is essential to the patient's oncology care plan.

I request an expedited review of this tier exception request. Please notify my office of your decision via fax at [Office Fax Number] or phone at [Office Phone Number].

Sincerely,

[Physician Signature]
Physician Name: [Physician Name, MD/DO]

NPI Number: [NPI Number]
Practice Name: [Clinic Name]

Attached: [Clinical notes, pathology reports, NCCN guidelines, or previous treatment history]