

Date: [Date]

To: [Insurance Company Name/Pharmacy Benefit Manager]

Attn: Appeals/Grievance Department

Fax/Address: [Fax Number or Mailing Address]

RE: Request for Formulary Tier Exception

Patient Name: [Patient Name]

Patient Date of Birth: [DOB]

Member ID Number: [Member ID]

Group Number: [Group Number]

Dear Medical Director,

I am writing to formally request a formulary tier reduction for my patient, [Patient Name], regarding the maintenance medication [Medication Name, Strength, and Dosage]. Currently, this medication is placed on Tier [Current Tier Number]. I am requesting that it be covered at the Tier [Requested Tier Number] cost-sharing level.

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. This is a chronic condition that requires long-term maintenance therapy to prevent [List potential complications or hospitalizations].

This request is based on the following medical necessity:

- **Treatment Failure:** The patient has previously tried and failed the following lower-tier alternatives: [List Drug A] and [List Drug B]. These medications were ineffective in controlling the patient's symptoms.
- **Contraindications:** Lower-tier alternatives such as [List Drugs] are contraindicated for this patient due to [List specific reasons, e.g., drug interactions, comorbid conditions].
- **Adverse Reactions:** The patient experienced intolerable side effects when taking [List Drug Name], specifically [Describe side effects].

[Medication Name] is the most appropriate clinical option for this patient's long-term health. Given that this is a maintenance drug required for life-long management, the current tier placement creates a financial hardship that may lead to non-adherence and subsequent medical complications.

Please review this request for a tier exception. If you require additional clinical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]
[Phone Number]