

Date: [Date]

To: [Insurance Company Name]

Department: Pharmacy Appeals Department

Address: [Insurance Company Address]

Fax Number: [Fax Number]

RE: Formulary Tier Exception Request

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Prescription Medication: [Medication Name and Dosage]

To Whom It May Concern,

I am writing to formally request a tier reduction for the medication [Medication Name] for my patient, [Patient Name]. This medication is currently placed on Tier [Current Tier Number] of your formulary. I am requesting that it be covered at the [Lower Tier Number] cost-sharing level.

This request is based on medical necessity. The patient has the following diagnosis:
[Diagnosis/ICD-10 Code].

I have determined that the lower-tier alternatives on your formulary are not suitable for this patient for the following reasons:

- **Alternative 1 [Name]:** [Reason: Ineffective, Contraindicated, or Adverse Reaction].
- **Alternative 2 [Name]:** [Reason: Ineffective, Contraindicated, or Adverse Reaction].

Given the patient's age and clinical history, [Medication Name] is the most appropriate and safest treatment to manage their condition and prevent further complications or hospitalization.

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]