Date: [Date]

Attn: Appeals and Grievances Department
[Health Insurance Company Name]
[Address]
[City, State, Zip Code]

RE: Subsequent Appeal for Formulary Tiering Exception

Member Name: [Member Name]
Member ID Number: [Member ID]
Claim/Reference Number: [Original Denial Reference Number]
Prescribed Medication: [Medication Name]
Requested Tier: [Target Tier Level, e.g., Tier 2 or Preferred]

Dear Appeals Committee,

This letter is a formal subsequent appeal regarding the denial of a formulary tiering exception for [Medication Name]. We previously requested that this medication be covered at a lower cost-sharing tier, which was denied on [Date of Denial]. We are providing additional clinical information to demonstrate why the current tiering placement creates an undue financial hardship and why alternative medications on lower tiers are clinically inappropriate for this patient.

Clinical Justification:

[Insert Physician's explanation of why lower-tier alternatives are contraindicated or have been ineffective for the patient. List specific side effects or lack of efficacy experienced with formulary drugs.]

Medical Necessity:

[Insert explanation of why the requested medication is the standard of care for the patient's specific condition and why a tier reduction is necessary to ensure treatment adherence.]

We have attached the following supporting documentation:

- Updated clinical notes and laboratory results.
- Previous pharmacy records showing failure of lower-tier alternatives.
- Peer-reviewed literature supporting the use of this specific medication for this diagnosis.

We request an immediate review of this appeal to ensure the patient has affordable access to this essential therapy. Please notify us of your decision within [Timeframe, e.g., 72 hours for expedited or 30 days for standard].

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]
[Phone Number]