Date: [Date]

To: [Health Plan Name]
Attention: Pharmacy Benefit Manager / Prior Authorization Department
Fax Number: [Fax Number]

RE: Formulary Exception Request for Biological Therapeutic

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

Dear Medical Director,

I am writing to request a formulary exception for **[Requested Biologic Name]** for the treatment of **[Diagnosis/ICD-10 Code]**. My patient has been under my care since [Date].

Clinical Justification:

The patient requires this specific biological therapeutic because:

- [Reason 1: e.g., Patient has failed preferred formulary alternatives: Name of Drug A, Name of Drug B]
- [Reason 2: e.g., Contraindications to preferred agents]
- [Reason 3: e.g., Patient is currently stable on this medication and switching poses a clinical risk]

Prior Treatments:

[List previous medications, dosages, dates of use, and reasons for discontinuation/failure].

Physician Assessment:

Based on the patient's medical history and the clinical profile of [Requested Biologic Name], I believe this medication is medically necessary. Delay in treatment or switching to a non-biological equivalent may result in disease progression or adverse outcomes.

Thank you for your prompt review of this request. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]

[Clinic Name]
[Phone/Fax Number]