Date: [Date]

To: [Insurance Company Name]
Attn: Pharmacy Prior Authorization Department
Fax Number: [Fax Number]

RE: Formulary Exception Request for Dispense As Written (DAW)

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

Dear Medical Director,

I am writing to request a formulary exception for my patient, [Patient Name], to receive the brand-name medication **[Brand Name Drug]** as "Dispense As Written" (DAW). I am requesting that the brand-name medication be covered at the preferred cost-sharing level due to medical necessity.

Diagnosis: [Diagnosis/ICD-10 Code]
Requested Medication: [Brand Name, Strength, Dosage, Frequency]

The patient has previously attempted therapy with the following formulary/generic alternatives, which were unsuccessful:

- **[Generic/Alternative Drug Name]:** Failed due to [Reason: e.g., allergic reaction, specific side effect, or lack of efficacy].
- **[Generic/Alternative Drug Name]:** Failed due to [Reason].

Clinical Justification:
[Provide clinical details here. Examples: Patient experienced breakthrough symptoms on the generic version; Patient has a documented allergy to an inactive ingredient/filler found in the generic equivalent; Patient has achieved stabilization on the brand name and switching poses a significant clinical risk.]

Based on the patient's medical history and the clinical failure of the required formulary alternatives, I request an immediate exception to allow the brand-name medication to be dispensed as written.

Please contact my office at [Phone Number] if you require additional information.

Sincerely,

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

NPI Number: [NPI Number]
Clinic Name: [Clinic/Practice Name]
Address: [Address, City, State, Zip]