Date: [Date]

To: [Insurance Provider Name / Pharmacy Benefit Manager]

Attention: Utilization Management / Pharmacy Department

Fax Number: [Fax Number]

RE: Request for Clinical Override / Prescription Substitution

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

Dear Medical Director,

I am writing to formally request a clinical override for my patient, [Patient Name], regarding the prescription for [Requested Medication Name]. It is my professional medical opinion that this specific medication is medically necessary and should be dispensed as written, without substitution for the formulary-preferred alternative, [Formulary Medication Name].

Reason for Clinical Override:

- **Previous Treatment Failure:** The patient has previously tried [Formulary Alternative] from [Date] to [Date] and experienced inadequate therapeutic response.
- **Adverse Reaction:** The patient experienced the following documented adverse effects when using the formulary alternative: [List Side Effects].
- **Contraindication:** The formulary-preferred medication is contraindicated for this patient due to [List Condition or Drug Interaction].
- **Clinical Stability:** The patient is currently stable on [Requested Medication Name]. Switching medications poses a significant risk of clinical decompensation or relapse.

Clinical Justification:
[Insert brief clinical summary of the patient's condition and why the requested drug is superior for this specific case.]

Based on the clinical evidence provided, I request that you grant an override to allow coverage for [Requested Medication Name] at the [Preferred/Standard] benefit level.

Please contact my office at [Phone Number] if you require additional documentation or have questions regarding this request.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
NPI Number: [NPI Number]
Practice Name: [Practice Name]
Phone: [Phone Number]
Fax: [Fax Number]