[Date]

To: [Insurance Provider Name / Pharmacy Benefit Manager]
Attention: Utilization Management Department
Member Name: [Patient Full Name]
Member ID: [Insurance ID Number]
Date of Birth: [DOB]

RE: Medical Necessity/Exemption Request for Brand Name Medication

To Whom It May Concern,

I am writing to formally request a medical necessity exemption for my patient, **[Patient Name]**, to receive the brand-name medication **[Brand Name Drug]** instead of the generic equivalent, **[Generic Name]**.

This request is based on a documented adverse reaction experienced by the patient while taking the generic version. The details of the clinical encounter are as follows:

- **Date(s) of Generic Trial:** [Start Date] to [End Date]
- **Adverse Reaction Experienced:** [Describe symptoms, e.g., severe allergic reaction, gastrointestinal distress, loss of efficacy, etc.]
- **Clinical Outcome:** [Describe how the reaction resolved after discontinuing the generic or switching to the brand name]

It is my professional medical opinion that the generic substitution is contraindicated for this patient due to [specific reason, e.g., sensitivity to inactive fillers or binders]. Continued use of the generic formulation poses a significant risk to the patient's health and treatment stability.

I request that you approve coverage for **[Brand Name Drug]** as "Dispense as Written" (DAW) and waive any higher cost-sharing or step-therapy requirements associated with this specific prescription.

Please contact my office at **[Phone Number]** if you require additional medical records or documentation.

Sincerely,

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