|  |  |
| --- | --- |
| [Date]  [Formulary director]  [Name of health plan]  [Mailing address] | Re: [Patient’s name]  [Plan identification number]  [Date of birth]  [Case identification] |

To whom it may concern:

My name is [HCP’s name], and I am a [board-certified medical specialty] [NPI]. I am writing to request a tiering exception for my patient, [patient’s name], who is currently a member of [name of health plan].\*

The prescription is for [product, dosage and frequency], which is medically appropriate and necessary for this patient who has been diagnosed with [condition], [ICD code(s)].

I am requesting that [product] be made available to my patient as a preferred medication.

In the past, [patient’s name] has attempted other treatments for [condition], but those trials have failed due to either inadequate efficacy or lack of tolerability.

|  |  |  |
| --- | --- | --- |
| **Past Treatment(s)†** | **Start/Stop Dates** | **Reason(s) for Discontinuing** |
| [Drug name] | [MM/YY] - [MM/YY] | [Please list side effects, lack of efficacy, etc] |
| [Drug name] | [MM/YY] - [MM/YY] | [Please list side effects, lack of efficacy, etc] |

The patient’s present treatment(s) are as follows:

|  |  |  |
| --- | --- | --- |
| **Current Treatment(s)†** | **Start Date** | **Dosage** |
| [Drug name] | [MM/YY] | [XX] |
| [Drug name] | [MM/YY] | [XX] |

Currently, [patient’s name] has the following unresolved symptoms:

|  |  |
| --- | --- |
| • [Symptom 1] | • [Symptom 2] |

Along with this letter, I have enclosed a copy of my patient’s medical records and a Letter of Medical Necessity.   
The letter describes why [product] is medically necessary for my patient’s care over the preferred drugs listed in   
the plan’s formulary.

[Explain why lower-tiered formulary drugs would not be as effective as product].

The reason I am requesting a tiering exception is because the cost associated with [product] assigned tier would present a financial burden to [patient’s name]. Furthermore, it prevents my patient from utilizing a medication that will help treat the [condition].

To summarize, I consider [product] to be the best option in successfully treating my patient’s [condition].   
Please contact me, [name], at [telephone number] to answer any pending questions.

Sincerely,

[Physician’s name and signature]

[Physician’s medical specialty] [Physician’s NPI]

[Physician’s practice name]

[Phone #] [Fax #]

Encl: [Medical records, photo(s), Letter of Medical Necessity, statement of financial hardship, case number, written response to denial]

NPI, National Provider Identifier

\*Include patient’s medical records and supporting documentation, including clinical evaluation, scoring forms, and photos of affected areas.

†Identify drug name, strength, dosage form, and therapeutic outcome.