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| [Date]  [Prior authorization department]  [Name of health plan or PBM]  [Mailing address] | Re: [Patient’s name]  [Plan identification number]  [Date of birth] |

To Whom It May Concern:

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

The prescription is for [product] [dosage and frequency], which is medically appropriate and necessary for this patient who has been diagnosed with [diagnosis], [ICD-10-CM code(s)]. Therefore, I am requesting that the plan remove any relevant NDC blocks, so that [product] can be made available to my patient as a preferred medication.

[Include reason for requesting this formulary exception. Examples could be as follows].

[Example one] The reason for my request is that this patient is currently treated with [product] [dosage and frequency] and is currently controlled.

[Example two] The reason for my request is that the dose of [product] [dosage and frequency] does not have an equivalent dosing option in another product and I feel that [product] [dosage and frequency] is medically appropriate and necessary for this patient.

[Or provide other reason]

A letter of medical necessity and pertinent medical records are enclosed, which offer additional support for the formulary exception request for [product] [dosage and frequency].

Please contact me, [physician’s name], at [telephone number] for a peer-to-peer review. I would be pleased to speak about why [a/an] [product] formulary exception is necessary for [patient’s name]’s treatment of [diagnosis].

Sincerely,

[Physician’s name and signature] [Patient’s name and signature]

[Physician’s medical specialty] [Physician’s NPI] [Patient’s contact information]

[Physician’s practice name]

[Phone #] [Fax #]

Enclosed: [Medical records, clinical trial information, letter of medical necessity]

\*Include patient’s medical records and supporting documentation.