Sample Letter of Formulary Exception: This sample letter is for demonstration purposes only. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for or to influence the clinical decision making of the prescribing healthcare professional.

[Insert Physician Letterhead]

[Insert Name of Medical Director]RE: Member Name: [Insert Member Name]

[Insert Payer Name]Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State Zip]

REQUEST: Authorization for treatment with [BRAND Name (generic name)]

DIAGNOSIS: [Insert Diagnosis] [Insert ICD]

DOSE AND FREQUENCY: [Insert Dose & Frequency]

REQUEST TYPE: ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director]:

I am writing to request a **formulary exception** for the above-mentioned patient to receive treatment with [Brand name (generic name)] for [insert indication]. My request is supported by the following:

Summary of Patient's Diagnosis

[Insert patient's diagnosis, date of diagnosis, lab results and date, current condition]

Summary of Patient's History

[Insert:

- Description of patient's symptoms
- Previous and/or current treatments for their disease and response to those interventions
- Summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with the drug

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

Rationale for Treatment

[Insert prescriber supporting statement, indicating that the non-formulary drug is necessary for treating the patient's condition because all covered drugs on any tier would not be as effective or would have adverse effects, the number of doses under a dose restriction has been or is likely to be less effective, or the alternative(s) listed on the formulary or required to be used in accordance with step therapy has been or is likely to be less effective or have adverse effects.]

[Consider including the patient's history, condition, and the full Prescribing Information supporting uses of [BRAND Name], and explain why you believe the believe treatment may be medically necessary and/or should be covered and reimbursed.]

[You may consider including documents that provide additional clinical information to support the recommendation for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

I look forward to your prompt review of this request. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

Enclosures [Include full Prescribing Information and the additional support noted above]