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

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 formulary 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 [diagnosis], [ICD 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.

**Patient’s history and symptoms\*:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_% of BSA impacted | |
| \_\_\_\_\_\_\_\_\_\_\_% of BSA involving only sensitive areas  \_\_\_\_\_\_\_\_\_\_\_Severity score index, assessed by: \_\_\_\_PASI \_\_\_\_Other (please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_Duration of illness | |
| \_\_\_ # of swollen joints |  |
| \_\_\_ # of tender joints | \_\_\_ Methotrexate (MTX) use (Y/N) |
| \_\_\_ ESR score | \_\_\_ Duration of MTX use \_\_\_ MTX dosage |
| \_\_\_ CRP score | \_\_\_ Other DMARD use; (specify) \_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| **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] |

[Include the main reason for requesting this formulary exception].

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

Please contact me, [HCP name], at [telephone number] for a peer-to-peer review. I would be pleased to speak about why a [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 #]

Encl: [Medical records, clinical trial information, photo(s), letter of medical necessity]

BSA, body surface area; CRP, c-reactive protein; DMARD, disease-modifying antirheumatic drug; ESR, erythrocyte sedimentation rate; NDC, national drug code; PASI, Psoriasis Area Severity Index.

\*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.