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| --- | --- |
| [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 [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].\*

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.

**Patient’s history and symptoms\*:**

|  |  |
| --- | --- |
| \_\_\_\_\_\_ Date of first migraine diagnosis | \_\_\_\_\_\_ Prior preventative medication (Y/N and note below) |
| \_\_\_\_\_\_ # of migraines per month | \_\_\_\_\_\_ Failure of prior CGRP medication (Y/N and note below) |
| \_\_\_\_\_\_ Average duration of migraine (hours/days) |  |
| \_\_\_\_\_\_ # of hospitalizations yearly due to migraine |  |

|  |  |  |
| --- | --- | --- |
| **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] |
| [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, [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]

CGRP, calcitonin gene-related peptide; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NDC, National Drug Code; NPI, National Provider Identifier.

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

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