[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, diagnosis, condition, and symptoms*:

_____ Duration of back pain

_____ Inflammation of sacroiliac joint (Y/N); if yes,____unilateral or____bilateral

_____ Limitation of movement in lower spine

_____ Limitation of chest expansion _____Diagnosis of stage III or IV CHF

_____ NSAID use (Y/N). If (Y):_____Name and duration of NSAID use;_____dosage

_____ MTX use (Y/N). If (Y):_____Duration of MTX use;_____MTX dosage

_____ Other DMARD use; (specify)_____

As required by some health plans, indicate with a check mark that patient does not have tuberculosis or other serious infections (including Hepatitis B and/or Hepatitis C).

_____Tuberculosis; Date of screening_____

_____Hepatitis B; Date of screening_____

_____Hepatitis C; Date of screening_____

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, [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]
[Physician's medical specialty] [Physician's NPI]
[Physician's practice name]
[Phone #] [Fax #]

Encl: [Medical records, clinical trial information, photo(s), Letter of Medical Necessity]

CHF, congestive heart failure; DMARD, disease-modifying antirheumatic drug; MTX, methotrexate; NPI, National Provider Identifier; NSAID, non-steroidal anti-inflammatory drug.

*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.

US-ABBV-220614 September 2022