[Your Name]
[Your Title/Position]
[Your Institution/Organization]
[Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Recipient Name]
[Recipient Title]
[Insurance Company/Pharmacy Benefit Manager Name]
[Address]
[City, State, Zip Code]

Dear [Recipient Name],

Subject: Formulary Exception Authorization Request for [Patient's Name, DOB: MM/DD/YYYY]

I am writing to request a formulary exception for my patient, [Patient's Name], who has been prescribed [Medication Name] for [Condition/Diagnosis]. This request is made on the grounds that the medication is medically necessary for the patient's treatment plan and not listed on the current formulary.

[Provide a brief clinical background for the patient, including relevant medical history and previous treatments tried.]

[Explain why the requested medication is essential for the patient's treatment and why other formulary alternatives are unsuitable or ineffective.]

Attached are supporting documents, including [relevant medical records, clinical notes, and any other pertinent information].

I appreciate your prompt attention to this matter and hope for a favorable review of this request for [Patient's Name]. Please feel free to contact me at [Your Phone Number] or [Your Email Address] should you require any additional information.

Thank you for your consideration.

Sincerely,

[Your Name]
[Your Title/Position]
[Your Institution/Organization]