[Prior authorization department] [Name of health plan]

[Mailing address]

[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 #]

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.

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