

Model Request for Additional Information

<Date>

<Enrollee Name>

Enrollee ID Number: <insert number>

<Street Address>

<City, State Zip Code>

Case Number: <insert number>

Dear <insert enrollee name>:

This letter is in response to your request for a <indicate type of request, e.g., formulary or tiering exception, expedited redetermination> that <you **or** your physician or other prescriber> filed with us on <insert date>.

[For a formulary exception request: A “formulary exception” request is when you ask for a drug that is not on <Plan sponsor name>’s list of covered drugs (called a "formulary"), or ask us not to apply a prior authorization or other requirement to a drug on our formulary.]

[For a tiering exception request: A “tiering exception” request is when you ask for a non-preferred drug at the preferred cost level.]

In order to process your request, we need additional information from your physician or other prescriber.

<Specifically describe the type of written documentation required from the physician or other prescriber.

For formulary exceptions, plan sponsors may require a statement that the drug is medically necessary to treat the enrollee’s condition because: (1) all of the covered drugs on the Plan’s formulary for the same condition would not be as effective for the enrollee as the non-formulary drug, would have adverse effects for the enrollee, or both; (2) step therapy has been or is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance, or has caused or is likely to cause an adverse reaction to the enrollee; or (3) the number of doses that is available under a dose restriction for the drug has been or is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance.

For tiering exceptions, plan sponsors may require a statement that the preferred drug for the treatment of the enrollee’s condition would not be as effective as the requested drug and/or that the preferred drug would have adverse effects for the enrollee.

If applicable, for either type of exception request, plan sponsors must also indicate if this letter is a request for additional supporting medical documentation.>

If you have any questions, please contact Customer Services at <toll-free number> <days and hours of operation>. TTY/TDD users should call <toll-free TTY number>.

Thank you.

<Plan sponsor name>