## Sample letter: Request for Tiering Exception

This letter is only an example.   
Please edit this letter to suit your patient’s needs and replace **bolded** sections with the appropriate information. Remove this portion before submitting to your patient’s insurance company.

[**Today’s date**]

[**Name of Medical Director**]  
[**Name of Insurance Company**]  
[**Mailing address of Insurance Company**]  
Re: [**Patient name**]  
[**Member Identification number**]  
[**Date of birth**]

Dear [**Name of Medical Director**],

I am contacting you on behalf of my patient, [**patient name (insurance ID#)**], to request a tiering exception. The request is for [**name of treatment/medicine**]. [**Name of treatment/medicine**] at [**dose and frequency**] is medically appropriate and necessary for [**name of patient**], who has been diagnosed with [**moderate/severe**] [**psoriasis and/or psoriatic arthritis**] [**ICD code(s)**]. This letter supports my request that [**name of treatment/medicine**] be made available to [**patient name**] as the preferred treatment.

[**Patient name**] is under my care for [**his/her**] [**psoriasis and/or psoriatic arthritis**]. [**He/She**] has [**number**] percent of body surface area affected by psoriasis. [**Psoriasis is also involved in sensitive areas including face/genitals**]. This categorizes [**his/her**] psoriasis as [**moderate/severe**]. [**Patient name**] has [**number**] of joint or sites affected by psoriatic arthritis and can be categorized as [**moderate/severe**]. [**Patient name**] started with [**treatment name/dose**] in [**year**]**.** [**Include any other treatments the patient has tried**]. Previous treatments have been unsuccessful due to [**list reasons**]**.**

Currently, [**name of patient**] is treating with [**name of treatment/medicine**], that started on [**start date**] with [**current disease status/outcome(s)**]. With the current treatment, [**he/she**] still presents with the unresolved symptoms of [**list unresolved symptoms**].

[**Explain how psoriasis affects patient’s personal or social life, work or ability to work, emotional well-being, or other aspects**].

[**Explain any comorbidities that patient has that is linked to psoriasis or psoriatic arthritis, such as heart disease, stroke, high blood pressure, diabetes, depression, or others**].

In view of [**name of patient**]’s signs, symptoms, and history, I feel that [**name of treatment/medicine**] is medically necessary. [**Insert rationale for prescribing treatment/medicine here, including your professional opinion of the patient’s likely benefit from treatment or disease progression without treatment. Include review of patient’s treatment history of treatment failure and contraindications to other treatments. Explain patient qualifications for pre-authorization requirements if possible or why an exception should be granted. Explain why lower-tired treatments would not be as effective as recommended treatment.**]. The reason that I am requesting a tiering exception is due to the costs associated with [**name of treatment/medicine**] that would be a financial burden to [**patient name**] despite the likely benefit from treatment with [**name of treatment/medicine**] that I consider to be the best option in successfully treating [**his/her**] [**psoriasis and/or psoriatic arthritis**].

Please feel free to contact me, [**physician name**], at [**office phone number**] or [**patient’s name**] at [**patient phone number**] for any additional information you may require. We look forward to receiving your timely response and approval of this claim.

Sincerely,

[**Physician name and signature**]  
[**Physician medical specialty**]  
[**Physician NPI**]  
[**Physician practice name**]  
[**Physician office mailing address**]  
[**Physician phone number**]  
[**Physician fax number**]

[**Patient name and signature]**

Encl: Medical records  
Supporting documentation  
Photo(s)  
Letter of Medical Necessity  
Statement of financial hardship from patient

CC:   [**Name of patient**]