|  |  |
| --- | --- |
| [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 [condition], [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\*:**

% of reduction in AN (abscesses and inflammatory nodules count relative to baseline)

Clinical Response, assessed by: HiSCR; No increase in abscess draining fistula

As required by some health plans, indicate with a check mark that patient does not have tuberculosis or other serious infections. If patient has any serious infections, please list them below.

Infection name and affected part(s) of body

Treatment type(s)

Treatment start/stop dates

Anticipated resolution date

|  |  |  |
| --- | --- | --- |
| **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]

HiSCR, Hidradenitis Suppurativa Clinical Response; AN, abscesses and nodules; NPI, National Provider Identifier

\*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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