Medicare Part D Sample Letter of Tier Change Request

IMPORTANT: When using this template, please be sure to include both the brand name and generic name of the product in the first paragraph.

[Insurance Company]
[Address]
[City, State, Zip]

Re: **[Patient Name]**
[Policy #]
[DOB]
[Address]
[City, State, Zip]

To Whom It May Concern:

I am writing on behalf of my patient, **[Patient Name, ID and Group Number]** to appeal for a tier change to a lower tier approval of **[Product name (generic name)]** associated with **[ICD10 Code]**. This letter of request for tier change approval includes the patient's relevant past medical history, overview of prior care delivered, treatment rationale and supporting medical necessity data. The supporting data included with this letter confirms that a lower tier should be approved for the patient due to the rationale provided below.

Patient's History, Past Treatments and Drugs Utilized (1500-character limit):
[Include information outlining when the patient was diagnosed and severity of symptoms].

Treatment Rationale (1500-character limit):
[Provide information on patient response to past treatments and anticipated prognosis and rationale for the currently prescribed product].

Supporting Study Data (1500-character limit):
[Include references to published medical study data evaluating the use of the currently prescribed product. Remember to include the FDA approved indications and usage].

In summary, the currently prescribed product is medically necessary for this patient's medical condition and should be given a more favorable tier level for the patient. Please contact me if any additional information is required to ensure the prompt approval of the currently prescribed product at a lower tier for the patient.

Sincerely,
[Physician Name and Signature]
[Phone #]