Medicare Part D Sample Letter of Tier Change Request
Physician's Letterhead

[Insurance Company]	Re: [Patient Name]
[Address]	[Policy #]
[City, State, Zip]	[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)] for the treatment of *[Diagnosis]*. 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 superiority of [Product name (generic name)] in treating the patient in comparison to drugs currently listed lower on the tier.

Patient's History, Past Treatments and Drugs Utilized:
[Include information outlining when the patient was diagnosed and severity of symptoms]

Treatment Rationale:
[Include information on past treatments and drugs utilized to treat the patient. Explain, as applicable, how the past treatments and drugs lower on the tier either did not effectively treat the patient, put the patient at risk, or other reasons for now prescribing Product name (generic name)]

Supporting Study Data
[Include references to published medical study data confirming the effectiveness of Product name (generic name). Provide a statement on FDA approval information for the indication of use]

In summary, [Product name (generic name)] 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 [Product name (generic name)] at a lower tier for the patient.

Sincerely,

[Physician Name and Signature]
[Phone #]