[Date]
[Health plan name]
ATTN: [Name of prior authorization department]
[Contact name (if available)]
[Health plan address]
[City, State ZIP]

[Patient name]
[Date of birth]
[Insurance ID number]
[Insurance group number]
[Case ID number]
[Date(s) of service]

Dear [Contact Name/Medical Director],

My patient [insert patient's full name] is a member of [insert name of health plan]. I am writing to you because [insert patient's first name] has been taking STELARA® (ustekinumab) for [insert how long the patient has been taking STELARA®] and is no longer able to because it is not preferred in the plan's formulary as a covered medication. It is necessary for [insert patient's first name] to take STELARA® because [insert why the patient's medical condition requires the use of STELARA®].

I am requesting that [insert patient's first name] receive an exception to your formulary to continue to get the STELARA® prescription covered.

DIAGNOSIS AND MEDICAL HISTORY
[Insert patient's first name] has been diagnosed with [insert the patient's diagnosis] [diagnosis code] and I have prescribed STELARA® as the therapy. I practice in the medical specialty of [insert medical specialty] at [insert your address]. [Insert patient's first name]'s past treatments included [list previous treatments and drugs]. I have enclosed [insert patient's first name]'s medical records and a Letter of Medical Necessity supporting my request for the formulary exception approval of STELARA®.

The main reasons I am requesting an exception for [insert patient's first name] are:
[Explain why it is medically necessary for the patient to take STELARA®].

[I am attaching the following supporting documents for your consideration:]
[PLEASE LIST SUPPORTING DOCUMENTS]

SUMMARY
The reasons I have mentioned above are supported by the information that I have enclosed. I can be contacted by email (insert your email address) or phone (insert your phone number) to answer any further questions or to participate in a peer-to-peer review discussing the importance of providing a formulary exception to allow [insert patient's first name] to take STELARA® as prescribed. I look forward to hearing your decision.

Thank you for your time and consideration.

Sincerely,
[Your signature]

ENCLOSURES
[List additional documents, which may include: health plan communications, Letter of Medical Necessity, and medical records, if available].