**Sample Format Tier Exception Letter\***

(\*Please note that this template is intended only as an example and should be customized with
 patient-specific details and information prior to submission to the payer.)

[Insert physician letterhead]

[Medical Director] RE: Patient Name

[Insurance Company] Policy Number

[Address] Claim Number

[City, State, ZIP]

Dear **[insert name of Medical Director]**:

My name is **[insert prescriber’s name]**, and I am a board-certified ophthalmologist **[insert prescriber NPI #].** I am writing to request a formulary tier exception for my patient, **[insert patient name]**, who is currently a member of **[insert health plan name]**.

The prescription has been submitted for once-a-day dosing of VYZULTA® (latanoprostene bunod ophthalmic solution), 0.024%, which is indicated for the reduction of intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension. In the case of **[insert patient name]**, this is medically appropriate and a necessary treatment.

I am requesting that this medication be made available to my patient as a preferred medication and not just a covered medication. In the past, **[insert patient name],** has attempted other treatments for **[insert condition]**, but those trials
have failed due to either inadequate efficacy or lack of tolerability. See below:

| **Past Treatment** | **Start/Stop Dates** | **Reason for Discontinuation** |
| --- | --- | --- |
| **[insert medication name]** | **[insert start date / insert stop date]** |  |
| **[insert medication name]** | **[insert start date / insert stop date]** |  |
| **[insert medication name]** | **[insert start date / insert stop date]** |  |

The patient’s present treatments are as follows:

| **Current Treatment** | **Start Date** | **Dosage** |
| --- | --- | --- |
| **[insert medication name]** | **[insert start date / insert stop date]** |  |
| **[insert medication name]** | **[insert start date / insert stop date]** |  |

Currently, **[insert patient name]** has the following unresolved symptoms:

* **[insert symptom(s)]**

Along with this letter, I have enclosed a copy of my patient’s progress notes and a letter of medical necessity. The letter describes why VYZULTA is medically necessary for **[insert patient name]** over the preferred drugs listed on the plan’s formulary.

The reason why I am requesting a tiering exception is because the cost associated with VYZULTA at Tier 3 would present a financial burden to **[insert patient name].**

To summarize, I consider VYZULTA to be the best option in successfully treating my patient’s **[insert medical diagnosis]**. Thank you for your consideration and please contact me directly at **[insert telephone number]** if I can answer any questions.

For full Prescribing Information, visit vyzulta.com or call Medical Information at (800) 321-4576 to request
that it be faxed, emailed, or mailed instead.

Sincerely,
**[Insert Doctor Name and participating provider number]**

Enclosures