

Payers may require prior authorization or supporting documentation to process and cover a claim for the requested therapy. A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific Appeal Letter - Formulary Exception will help to explain the physician's rationale and clinical decision-making in choosing a therapy. The following is a sample Appeal Letter - Formulary Exception that can be customized based on your patient's medical history and physical examination. Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.

[Insert letterhead with physician's name and address]

Sample Format: Appeal Letter – Formulary Exception

[Date]

[Payer Name]

[Payer Address]

[Payer City, State, Zip Code]

ATTN: **[Appeals Department]**

RE: **[Patient Name]**

[Policy ID/Group Number]

[Date of Service]

To whom it may concern,

I am writing to request a formulary exception be granted for the treatment of **[insert patient's name]** with Recorlev® (levoketoconazole) 150 mg tablets for **[insert diagnosis]**. **[Insert payer's name]** does not include Recorlev on the approved formulary list.

Recorlev was approved by the US Food and Drug Administration in December 2021. Recorlev is a cortisol synthesis inhibitor that was systematically studied in patients with Cushing's syndrome.

Recorlev is indicated for the treatment of endogenous hypercortisolemia in adult patients with Cushing's syndrome for whom surgery is not an option or has not been curative. Recorlev is not approved for the treatment of fungal infections.

[Insert patient's name] is diagnosed with **[insert patient's diagnosis]**. I am a **[insert physician's credentials]**, and I believe that Recorlev is the appropriate treatment. It is imperative that a formulary exception be made.

In my clinical judgment, treatment with Recorlev is medically necessary because **[list the clinical justification(s) for the use of Recorlev]**.

I have enclosed additional documentation that supports this patient's need for treatment with Recorlev. In the best interest of my patient, I would appreciate your immediate review and ask that a formulary exception be granted. If you have further questions, please feel free to call me at **[insert telephone number]** to discuss.

Thank you in advance for your immediate attention to this request.

Sincerely,

[Insert physician's name and participating provider number]

[Enclosures (suggested documents): Formulary Exception Request Form, if required (available on payer's website), original Prior Authorization Request Form, Denial Letter/EOB, patient medical history, and other supporting documents]

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SAMPLE