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Re: Medical Exemption Request

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Member ID: \_\_\_\_\_

Policy or Group Number: \_\_\_\_\_

Case ID Number: \_\_\_\_\_

To Whom It May Concern:

I understand that the \_\_\_\_\_ policy for \_\_\_\_\_ requires \_\_\_\_\_ prior to approving treatment with \_\_\_\_\_ . However, I believe that \_\_\_\_\_ requires \_\_\_\_\_ without \_\_\_\_\_ due to clinical and medical circumstances.

Please see below for details about symptoms, previous treatments, medical history, and treatment rationale that supports the claim for medical exception for \_\_\_\_\_.

**Patient Clinical/Medical History**

ICD-10-CM diagnosis code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Date of patient's first visit: \_\_\_\_\_

Date of referral: \_\_\_\_\_

Patient's performance status: \_\_\_\_\_

Prior treatments including product name, duration, and response:

Reason for discontinuation: \_\_\_\_\_

Patient's disease progression history: \_\_\_\_\_

Other factors impacting product treatment selection: \_\_\_\_\_

**Justification for Medical Exception**

Clinical rationale for treatment with product name(s):

Why plan requirement is not appropriate for patient:

Concerns, including experience on similar therapies, adverse events, or other considerations:

**Treatment Plan**

Product name(s): \_\_\_\_\_

How administered (oral, IV infusion, topical): \_\_\_\_\_

Dosage frequency: \_\_\_\_\_

Duration of treatment:

Treatment schedule:

**Summary**

Based on the above information, I hope you agree \_\_\_\_\_ is an appropriate treatment for \_\_\_\_\_. A timely approval of \_\_\_\_\_ by \_\_\_\_\_ without \_\_\_\_\_ would be greatly appreciated by myself and my patient. If you have any questions about approving this medical exception, please do not hesitate to call me at \_\_\_\_\_. Thank you for your prompt attention.

Sincerely,

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Enclosures: