**[Physician letterhead/stationery]**

**[Date]**

**[Formulary director’s name]**

**[Health plan/insurance company]**

**[Address]**

**[City, State, Zip]**

RE: **[Patient’s name]**

Policy number: **[Policy number]**

Formulary exception requested for VELTASSA® (patiromer) For Oral Suspension

Dear **[formulary director’s name]**,

I am sending this letter on behalf of my patient, **[patient’s name]**, who is currently a member of **[health plan’s name]**. I am requesting a formulary exception for **[his/her]** prescription of VELTASSA. **[If this formulary exception request is an appeal, replace previous sentence with this text:** This is a formulary exception appeal. I have included a copy of the original denial letter and medical notes in response to the denial.**]** Currently, VELTASSA is not listed on **[health plan’s name]**’s formulary. Treatment with VELTASSA **[dose and frequency]** is medically appropriate and necessary for **[patient’s name]**. This letter serves to request that VELTASSA be available to **[patient’s name]** as a preferred drug and that any applicable NDC blocks be removed.

Past treatments and drugs that have been unsuccessful in achieving long-term control of symptoms for **[patient’s name]** include **[insert list of past treatments and drugs]**. Currently, **[he/she]** has the following unresolved symptoms: **[list patient’s symptoms]**. The main reasons that I am requesting this exception are **[insert main medical necessity points]**.

Please find an enclosed letter of medical necessity and additional information, including **[list relevant documentation]**, that support this treatment decision. I have prescribed VELTASSA as a medically necessary part of my patient’s treatment plan. Please contact me at **[physician’s telephone number]** for a peer-to-peer review or to answer any pending questions.

Thank you for your immediate attention to this very important matter.

Sincerely,

**[Physician’s signature]**, **[medical degree]**

**[Insert physician’s name]**

**Suggested enclosures:**

Letter of medical necessity

Package insert for VELTASSA

Medical records

Clinical records (eg, laboratory reports) that support the need for VELTASSA

Other supporting documentation

Copy of denial letter, if applicable

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