[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],

I am a member of [insert name of health plan]. I am writing to you because I have been taking STELARA® (ustekinumab) for [insert how long you have been taking STELARA®] and I am no longer able to because it is not preferred in my plan's formulary as a covered medication. According to my doctor, it is necessary for me to take STELARA® because [insert why, according to your doctor, your medical condition requires the use of STELARA®].

I am requesting an exception to your formulary so that I can continue to get my STELARA® prescription covered.

DIAGNOSIS AND MEDICAL HISTORY
I have been diagnosed with [insert the diagnosis provided to you by your doctor] [diagnosis code] and my doctor has prescribed STELARA® as my therapy. Dr. [insert doctor's name] practices in the medical specialty of [insert medical specialty] at [insert doctor's address]. My past treatments included [work with your doctor to provide your previous treatments for this condition]. I have enclosed my medical records and a Letter of Medical Necessity from my doctor supporting my request for the formulary exception approval of STELARA®.

The main reasons I am requesting an exception are:
[Work with your doctor to provide the reasons why it is medically necessary for you to continue taking 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.

Please reach out to me by email (insert your email address) or phone (insert your phone number) if you have any questions on my request. My doctor can be contacted at [insert doctor's 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 me to take STELARA® as prescribed by my doctor.

I look forward to hearing your decision.

Thank you for your time and consideration.

Sincerely,
[Patient and doctor's signatures]

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