**Sample Tiering Exception Request Letter** **for ARCALYST® (rilonacept)**

***This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when requesting a tiering exception for ARCALYST from a patient’s insurance company. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for, or to influence, the independent clinical decision of the prescribing healthcare professional.***

**[Physician or Practice Letterhead]**

**[Date]**

**[Health Plan Name]** Patient: **[Patient’s First and Last Name]**

Attn: **[Department]** Date of Birth: **[Patient’s Date of Birth]**

**[Health Plan Contact]** Member ID #: **[Patient’s Member ID #]**

**[Health Plan Address]** Member Group #: **[Patient’s Group ID #]**

**[Health Plan City, State ZIP]** Claim #: **[Claim #]**

Request: Tiering exception for ARCALYST® (rilonacept) injection for subcutaneous use

Diagnosis: **[Diagnosis]** (**[ICD-10 code(s)]**)

Dosage: **[Dose and frequency]**

Dear **[Health Plan Contact]**,

I an writing to request a tiering exception for ARCALYST on behalf of my patient, **[Patient Name]**, who is currently a member of **[Health Plan Name]**. This request is for ARCALYST, which is medically appropriate and necessary for this patient diagnosed with **[diagnosis]** (**[ICD-10 code(s)]**), to be made available as a preferred medication.

Other treatments that **[Patient Name]** is taking or has taken for **[diagnosis]** (**[ICD-10 code(s)]**) have not demonstrated adequate efficacy or have led to tolerability issues.

|  |  |  |
| --- | --- | --- |
| **Treatment** | **Start/Stop Dates** | **Responses to Treatment (eg, lack of efficacy, intolerability)** |
| **[Drug Name]** | **[MM/YY] – [MM/YY]** | **[Please list reasons]** |
| **[Drug Name]** | **[MM/YY] – [MM/YY]** | **[Please list reasons]** |

I have enclosed a copy of the patient’s medical records along with a Letter of Medical Necessity. The letter details the reasons why ARCALYST is medically necessary for my patient’s care over the preferred drugs listed in the plan’s formulary.

I am requesting a tiering exception because the cost associated with the assigned tier for ARCALYST would present a financial hardship for **[Patient Name]** and prevent **[him/her]** from being able to access a medication that will help manage **[his/her]** **[diagnosis]** (**[ICD-10 code(s)]**).

Considering the patient’s diagnosis, medical history, and the clinical evidence supporting the efficacy of ARCALYST® (rilonacept) in treating **[diagnosis]** (**[ICD-10 code(s)]**). I believe treatment with ARCALYST is warranted, appropriate, and medically necessary. If you have any questions, please contact me at **[physician phone number and/or email]**. I would be pleased to speak to you in more detail about why **[Patient Name]** would benefit from a tiering exception.

I look forward to receiving your timely response.

Sincerely,

**[Physician Name]**

**[Physician signature]**

**[Physician address]**

**[Physician phone number]**

**Enclosures**

**[Include supporting evidence, such as relevant medical records, clinical notes/diagnostic reports, medication records, ARCALYST Prescribing Information, relevant peer-reviewed journal articles, and the FDA Approval Letter for ARCALYST.]**