Date: [Date]

To: [Insurance Company Name]
Attn: Appeals Department / Medical Director
Fax: [Fax Number]

RE: Letter of Medical Necessity for Step Therapy Exception

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case/Reference Number: [Case ID, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request an expedited exception to the step therapy (fail-first) requirements for the treatment of [Diagnosis, e.g., Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis] (ICD-10 code: [ICD Code]).

I have prescribed **[Requested Biologic Medication]**. It is my professional medical opinion that the plan-preferred alternatives ([List preferred drugs]) are contraindicated or would be clinically ineffective for this patient for the following reasons:

Clinical Justification:

- **Previous Treatment History:** The patient has already tried and failed the following medications: [List medications, dates of use, and reason for failure, e.g., lack of efficacy or adverse reaction].
- **Disease Severity:** The patient currently presents with [List symptoms/disease markers, e.g., high ESR/CRP, joint erosions, or functional impairment].
- **Comorbidities:** The preferred agent is contraindicated due to [List comorbid conditions, e.g., history of serious infections, malignancy, or heart failure].
- **Risk of Delay:** Requiring the patient to fail additional therapies will result in irreversible joint damage, permanent disability, and a significant decrease in quality of life.

Based on the patient's clinical profile and the severity of their condition, [Requested Biologic Medication] is the most appropriate and medically necessary treatment at this time. I request that you grant an immediate exception to the step therapy protocol and authorize coverage for this medication.

Please contact my office at [Phone Number] if you require additional clinical documentation or have any questions.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic Name]
[NPI Number]
[Phone Number]