[Date]

[Insurance Company Name]
[Appeals/Pharmacy Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Step Therapy Exception

Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Member ID Number: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing on behalf of my patient, **[Patient Name]**, to request an exception to your step therapy requirements for the medication **[Requested Medication Name]**. My patient has been diagnosed with **[Diagnosis Name/ICD-10 Code]**.

I am requesting this exception based on the following clinical grounds:

1. Previous Treatment Failure: The patient has already tried and failed the following formulary alternatives:

- **[Drug Name]:** Tried from [Dates] to [Dates]. Reason for discontinuation: [e.g., Lack of efficacy/Severe side effects].
- **[Drug Name]:** Tried from [Dates] to [Dates]. Reason for discontinuation: [e.g., Inadequate response].

2. Contraindications: The preferred formulary medications (**[List Medications]**) are clinically inappropriate for this patient because **[Reason: e.g., drug interaction with current regimen, comorbid medical condition, or previous adverse reaction to same drug class]**.

3. Clinical Stability: The patient is currently stable on **[Requested Medication Name]**. Switching to a different agent poses a significant risk of clinical relapse, hospitalization, or **[Other Risk]**.

In my professional medical opinion, **[Requested Medication Name]** is medically necessary for this patient's psychiatric stability. Requiring the patient to fail additional medications first would be detrimental to their mental health and safety.

Please expedite the approval of this request. If you require further information, I can be reached at **[Phone Number]**.

Sincerely,

[Physician Signature]

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