Date: [Date]

To: [Insurance Company Name]
Attn: Appeals/Prior Authorization Department
Fax: [Fax Number]

RE: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]
Claim/Reference Number: [Reference Number]

Dear Medical Director,

I am writing on behalf of [Patient Name] to request a step therapy exception for the medication **[Requested Medication Name]**. My patient has been diagnosed with Chronic/Episodic Migraine (ICD-10: [Code]) and requires this specific prophylaxis for medical stability.

Clinical History:
The patient experiences [Number] headache days per month. These migraines are characterized by [Symptoms: e.g., severe throbbing, photophobia, nausea] and significantly impair activities of daily living.

Requirement for Exception (Failed Therapies):
The patient has already attempted and failed the following preferred formulary medications:

- [Medication Name 1]: Tried for [Duration], failed due to [Reason: e.g., lack of efficacy/intolerable side effects].
- [Medication Name 2]: Tried for [Duration], failed due to [Reason: e.g., lack of efficacy/intolerable side effects].
- [Medication Name 3]: Tried for [Duration], failed due to [Reason: e.g., contraindication].

Clinical Justification:
Based on the patient's clinical history and the failure of standard oral prophylactics (including beta-blockers, anticonvulsants, or antidepressants), **[Requested Medication Name]** is medically necessary. Requiring further step therapy on [Formulary Medication] would likely result in [Expected Adverse Outcome/Treatment Delay].

I request that you approve this exception and provide coverage for [Requested Medication Name] as prescribed. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[Clinic Name]
[NPI Number]