Date: [Date]

TO: [Insurance Company Name]
ATTN: [Appeals/Medical Review Department]
FAX: [Fax Number]

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

Subject: Letter of Medical Necessity for Step Therapy Exception

Dear Medical Director,

I am writing on behalf of [Patient Name] to request an exception to your step therapy requirements for the treatment of Crohn's Disease (ICD-10: K50.90). I am requesting immediate coverage for **[Requested Medication Name]**.

The patient is currently experiencing [mention symptoms: e.g., severe abdominal pain, frequent bloody stools, weight loss]. Clinical assessments, including [mention tests: e.g., colonoscopy, CT enterography, fecal calpropectin], indicate [mention severity: e.g., moderate-to-severe active disease].

Your current policy requires the patient to first fail therapy with [Name of Required Step Therapy Drug(s)]. I am requesting an exception based on the following medical rationale:

- **Contraindication:** The required medication is contraindicated for this patient due to [Reason].
- **Clinical Inappropriateness:** Based on the patient's disease phenotype and severity, the required medication is expected to be ineffective.
- **Risk of Irreversible Damage:** Delaying treatment with the requested medication poses a significant risk of disease progression, bowel obstruction, or surgical intervention.
- **Previous Failure:** The patient has previously trialed and failed [Name of Drug] from [Start Date] to [End Date] due to [Reason: e.g., lack of efficacy/intolerable side effects].

Based on [Patient Name]'s clinical history and the progressive nature of Crohn's disease, **[Requested Medication Name]** is medically necessary to achieve clinical remission and prevent long-term complications. I request an expedited review of this request.

Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

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