DATE: [Date]

TO: [Insurance Company Name]
ATTN: [Appeals/Prior Authorization Department]
FAX: [Fax Number]

RE: Letter of Medical Necessity for Step Therapy Exception

PATIENT NAME: [Patient Name]
DATE OF BIRTH: [DOB]
POLICY ID: [Policy ID Number]
GROUP NUMBER: [Group Number]
CLAIM/REFERENCE NUMBER: [Reference Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request an expedited exception to your step therapy requirements for the following medication: **[Requested Medication Name, Dose, and Frequency]**. [Patient Name] has been under my care for the treatment of [Diagnosis/ICD-10 Code, e.g., Type 2 Diabetes Mellitus].

Clinical Justification:
The patient requires [Requested Medication] because the plan-preferred alternatives are clinically inappropriate for this specific patient. The patient has already attempted and failed the following formulary medications:

- **[Failed Medication 1]:** Used from [Dates] to [Dates]. Reason for discontinuation: [e.g., Inadequate glycemic control / Severe GI side effects].
- **[Failed Medication 2]:** Used from [Dates] to [Dates]. Reason for discontinuation: [e.g., Allergic reaction / Contraindicated due to renal impairment].

Contraindications:
Furthermore, the preferred medication(s) [Name of Preferred Drugs] are contraindicated for this patient due to: [List specific comorbid conditions, e.g., Stage 4 Chronic Kidney Disease, History of Pancreatitis, or specific drug interactions].

Provider Recommendation:
Based on the patient's medical history and current clinical status (Current HbA1c: [Value]%), [Requested Medication] is medically necessary. Delaying access to this treatment by requiring further step therapy increases the risk of acute complications, including hyperglycemia, cardiovascular events, and permanent organ damage.

I request that you approve this exception immediately to ensure the continuity of care and stabilization of the patient's blood glucose levels.

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

Sincerely,

[Physician Signature]

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