DATE: [Date]

TO: [Insurance Company Name]
ATTN: Pharmacy Benefit Manager / Appeals Department
FAX: [Fax Number]

RE: Letter of Medical Necessity for Step Therapy Exception
PATIENT: [Patient Name]
DATE OF BIRTH: [Patient DOB]
MEMBER ID: [Insurance ID Number]
CLAIM/REFERENCE #: [Reference Number if applicable]

Dear Medical Director,

I am writing on behalf of [Patient Name] to request an exception to the step therapy requirement for the cholesterol-lowering medication **[Requested Medication Name, e.g., Repatha, Praluent, Nexletol]**. This medication is medically necessary for the treatment of [Primary Diagnosis, e.g., Heterozygous Familial Hypercholesterolemia (HeFH) or Atherosclerotic Cardiovascular Disease (ASCVD)].

Clinical Documentation:
The patient presents with high-risk cardiovascular factors, including: [List factors, e.g., history of MI, stroke, or stents]. Current LDL-C levels remain elevated at [Current LDL Level] mg/dL, which is significantly above the target goal of [Target Level] mg/dL despite lifestyle modifications and pharmacological intervention.

History of Failed Therapies (Step Therapy Documentation):
The patient has already attempted and failed the following preferred formulary medications:

- **[Medication 1]:** Tried from [Date] to [Date]. Result: [e.g., Inadequate LDL reduction / Intolerable muscle pain (Statin Myopathy)].
- **[Medication 2]:** Tried from [Date] to [Date]. Result: [e.g., Persistent elevation of liver enzymes / Allergic reaction].
- **Ezetimibe (Zetia):** Tried from [Date] to [Date]. Result: [e.g., Insufficient response when added to maximally tolerated statin].

Clinical Justification:
Based on the patient's clinical history and the failure of the preferred agents listed above, I have determined that continuing with the standard step therapy protocol would likely result in an adverse clinical outcome or permanent physical harm to the patient. **[Requested Medication]** is the most appropriate next step in this patient's treatment plan to mitigate the risk of a future cardiovascular event.

I request that you approve this exception and provide coverage for [Requested Medication] immediately. Please contact my office at [Phone Number] if you require additional medical records or laboratory results.

Sincerely,

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