[Date]

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

RE: Letter of Medical Necessity for Step Therapy Exception
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request a step therapy exception for the medication **[Requested Medication Name]**. This treatment is medically necessary for the management of the patient's **Severe Persistent Asthma (ICD-10: [Code])**.

Clinical Documentation:

- **Current Symptoms:** [List symptoms: e.g., nocturnal awakenings, frequent use of rescue inhaler, shortness of breath].
- **Lung Function:** [Insert recent FEV1 or Peak Flow data].
- **Exacerbation History:** [Number of ER visits, hospitalizations, or oral corticosteroid bursts in the last 12 months].

Rationale for Exception:

The patient has previously tried and failed the following preferred formulary medications:

- [Medication Name]: [Dates used] - Result: [Inadequate control/Side effects]
- [Medication Name]: [Dates used] - Result: [Inadequate control/Side effects]

Based on the patient's clinical profile, including [Specific Biomarkers: e.g., Eosinophil count or IgE levels], the requested medication **[Requested Medication Name]** is the most appropriate therapy. Forcing the patient to trial additional formulary alternatives would likely result in significant clinical decline, increased risk of severe exacerbations, and potential hospitalization.

I request an immediate approval for this life-saving medication. Please contact my office at [Phone Number] if you require further clinical information.

Sincerely,

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

[Clinic/Practice Name]
[NPI Number]
[Phone Number]