[Date]

[Health Plan Name]
[Appeals/Pharmacy Department Address]
[City, State, Zip Code]

RE: Request for Medical Necessity Exception for Targeted Analgesic Step Therapy

Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Member ID Number: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a medical necessity exception to the step therapy requirements for **[Requested Medication Name]**. As the patient's treating pain management specialist, I have determined that this specific targeted analgesic is essential for the management of the patient's chronic pain condition.

Clinical Diagnosis: [Primary Diagnosis and ICD-10 Code]
Requested Medication: [Drug Name, Dosage, and Frequency]

Clinical Justification:
The patient has been diagnosed with [detailed diagnosis]. Currently, the patient's pain is [description of severity/functional impact]. The standard step therapy protocols requiring the use of [Required Step Therapy Drugs] are inappropriate for this patient for the following reasons:

- **Trial Failure:** The patient has previously tried and failed [List failed medications] from [Start Date] to [End Date]. These medications failed to provide adequate pain relief or caused intolerable side effects, specifically [List side effects].
- **Contraindications:** The preferred formulary medications are contraindicated for this patient due to [List co-morbidities or potential drug interactions].
- **Clinical Stability:** The patient is currently stable on [Requested Medication], and switching to a different analgesic would risk a significant setback in pain control, increased emergency room visits, or loss of physical function.

Physician's Recommendation:
Based on the patient's medical history and the specific pharmacological profile of **[Requested Medication]**, it is my professional opinion that this medication is the most appropriate and safest treatment option. Forcing the patient to undergo further step therapy would be detrimental to their health and quality of life.

I request that you grant an immediate exception and authorize coverage for **[Requested Medication]**. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician Signature]

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