Date: [Date]
To: [Insurance Company Name]
Attention: Pharmacy Benefit Manager / Appeals Department
Fax Number: [Fax Number]

RE: Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]

Dear Medical Director,

I am writing to formally request a Step Therapy Exception for [Patient Name] regarding the medication **[Requested Medication Name, Dose, and Frequency]**. This patient has been diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), ICD-10 code [Insert Code, e.g., F90.2].

The patient's current treatment plan requires the use of [Requested Medication] rather than the formulary-preferred alternatives (Step Therapy) for the following medical reasons:

- **Previous Treatment Failure:** The patient has previously tried and failed the following preferred medications: [List Failed Medications, Dates, and Reasons for Failure, e.g., lack of efficacy or intolerable side effects].
- **Clinical Contraindications:** Preferred stimulant(s) [Name of Preferred Drugs] are contraindicated for this patient due to [List Specific Medical Reason, e.g., history of severe anxiety, cardiac concerns, or specific comorbid conditions].
- **Clinical Stability:** The patient is currently stable on [Requested Medication]. Switching to a different stimulant would pose a significant risk of clinical regression, academic failure, and disruption of daily functioning.

Based on the patient's clinical history and the pharmacological profile of [Requested Medication], it is my professional medical opinion that this specific treatment is medically necessary and that requiring the patient to trial additional preferred stimulants would be detrimental to their health and safety.

I request that you approve this exception immediately. Please contact my office at [Office Phone Number] if you require additional documentation or clinical notes.

Sincerely,

[Provider Signature]
[Provider Name, Credentials]
[Clinic Name]
[NPI Number]