[Date]

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

RE: Letter of Medical Necessity for Step Therapy Exception
Patient Name: [Patient First and Last Name]
Patient Date of Birth: [MM/DD/YYYY]
Policy Number: [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 exception to your step therapy requirement for [Requested Medication Name]. Based on the patient's medical history and clinical presentation, the formulary-required medication(s) are medically inappropriate due to documented adverse reactions.

Diagnosis: [Diagnosis Name and ICD-10 Code]
Requested Medication: [Drug Name, Dosage, and Frequency]
Anticipated Duration of Treatment: [Duration]

Clinical Justification:
The patient has previously attempted treatment with the following required step therapy agent(s):

- **Medication Name:** [Failed Medication Name]
- **Dates of Trial:** [Start Date] to [End Date]
- **Documented Adverse Reaction:** [Describe specific side effects or allergic reactions experienced by the patient].

Due to the severity of this reaction, [Patient Name] cannot safely continue or re-attempt treatment with [Failed Medication Name]. Continuing the step therapy protocol would pose a significant risk to the patient's health and clinical stability.

In my professional medical opinion, [Requested Medication Name] is medically necessary for this patient. Please grant an immediate exception to the step therapy requirements to ensure the patient receives the appropriate standard of care.

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]
[Phone Number]