[Date]
[Insurance Company Name]
[Prior Authorization Department]
[Fax Number / Address]

RE: Letter of Medical Necessity for Step Therapy Exception
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Case ID: [Reference Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request an exception to the formulary step therapy requirements for [Requested Medication Name]. My patient has been diagnosed with [Diagnosis/ICD-10 Code].

The current step therapy protocol requires the patient to utilize [Name of Formulary Drug(s)] before granting access to [Requested Medication]. However, I am requesting a bypass of this requirement for the following medical reason(s):

- **Previous Treatment Failure:** The patient has already tried [Name of Failed Drug(s)] from [Start Date] to [End Date]. This treatment was ineffective in managing the patient's symptoms and resulted in [Briefly describe clinical failure].
- **Contraindication:** The formulary drug(s) are contraindicated for this patient due to [Specific medical reason, allergy, or co-morbidity].
- **Risk of Adverse Reaction:** Based on the patient's clinical history, there is a high probability that the formulary drug(s) will cause [Specific adverse event/side effect].
- **Clinical Stability:** The patient is currently stable on [Requested Medication], and switching to a formulary alternative would pose a significant risk of medical relapse or emergency hospitalization.

Based on the patient's medical history and the severity of their condition, [Requested Medication] is medically necessary. Requiring the patient to follow the standard step therapy protocol would result in unnecessary clinical delay and potential harm.

I have attached [List attachments: e.g., clinic notes, lab results, or previous pharmacy records] to support this request. I urge you to approve this authorization immediately.

Sincerely,

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