

**[Clinic Letterhead]**

[Date]

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

**RE: Letter of Medical Necessity for Step Therapy Exception**

**Patient Name:** [Patient Full Name]  
**Date of Birth:** [DOB]  
**Member ID:** [Member ID Number]  
**Policy Number:** [Policy Number]  
**Claim/Reference Number:** [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally request a step therapy exception for [Patient Name] regarding the medication [**Requested Medication Name**] for the treatment of **Rheumatoid Arthritis (ICD-10: [Code])**.

**Clinical Justification:**

The patient has been diagnosed with moderate-to-severe Rheumatoid Arthritis since [Year]. Based on their current clinical status, including [mention symptoms: e.g., high disease activity, joint erosions, elevated ESR/CRP], the requested treatment is medically necessary.

**Trial and Failure History:**

The patient has already trialed and failed the following plan-preferred medications:

- [Medication 1]: [Dates used] - Reason for failure: [e.g., Lack of efficacy/Side effects]
- [Medication 2]: [Dates used] - Reason for failure: [e.g., Persistent flares/Inadequate response]

**Rationale for Exception:**

Requiring the patient to trial [Plan Preferred Medication] would be clinically inappropriate because:

[Insert reason: e.g., Potential drug interaction with current meds / Pre-existing contraindication / Risk of irreversible joint damage / Patient is currently stable on requested medication and switching poses a risk of relapse].

In my professional medical opinion, the requested medication is the most appropriate treatment to prevent further disability and manage this patient's chronic condition. I urge you to approve this exception immediately.

Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic Name]