DATE: [Date]

TO: [Insurance Company Name]
ATTN: Appeals/Prior Authorization Department
FAX: [Insurance Fax Number]

RE: Letter of Medical Necessity for Step Therapy Exception

PATIENT NAME: [Patient Name]
DATE OF BIRTH: [DOB]
POLICY NUMBER: [Policy ID]
GROUP NUMBER: [Group Number]

Dear Medical Director,

I am writing to request a step therapy exception for my patient, [Patient Name], for the medication **[Requested Medication Name]**. This patient has been diagnosed with [Diagnosis/ICD-10 Code].

Clinical Justification:
The patient has previously attempted and failed the following formulary-preferred antidepressants:

- [Drug Name 1]: [Dates used]. Reason for failure: [e.g., Lack of efficacy/Severe side effects].
- [Drug Name 2]: [Dates used]. Reason for failure: [e.g., Lack of efficacy/Severe side effects].

Reason for Exception:
Requiring the patient to try additional formulary agents (step therapy) is medically inappropriate because:
[Select one or more: The patient has a contraindication to the required drugs / The required drugs are expected to be ineffective based on clinical history / The patient is currently stable on the requested medication.]

Based on the patient's psychiatric history and the severity of their symptoms, it is my professional opinion that [Requested Medication Name] is medically necessary to prevent further clinical decline.

Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Name]
[NPI Number]
[Clinic Name]