[Physician Name]
[Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

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

RE: Letter of Medical Necessity for Step Therapy Exception
Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Member ID: [Member ID]
Group Number: [Group Number]
Requested Medication: [Name of Requested Drug]

Dear Medical Director,

I am writing to formally request a step therapy exception for [Patient Name], who is currently under my care for the treatment of [Crohn's Disease / Ulcerative Colitis] (ICD-10: [Code]).

Based on the patient's clinical history and the severity of their disease, it is my professional medical opinion that the plan-mandated step therapy protocol is contraindicated and that the requested medication, [Requested Drug], is medically necessary.

Clinical Justification:
The patient is currently experiencing [list symptoms, e.g., severe abdominal pain, bloody stools, weight loss, frequent flares]. Objective data including [list recent labs/imaging/endoscopy results] confirm active inflammation and high risk for disease progression, including [strictures, fistulas, or surgery].

Previous Therapies and Failures:
The patient has previously tried and failed the following medications:

- [Drug Name 1]: [Dates used] - [Reason for failure/side effects]
- [Drug Name 2]: [Dates used] - [Reason for failure/side effects]

Rationale for Exception:
Requiring the patient to try [Plan Required Drug] before [Requested Drug] would be detrimental to their health because:

- [Reason 1: e.g., Similar mechanism of action to previously failed drugs]
- [Reason 2: e.g., Patient has comorbidities that contraindicate the required drug]
- [Reason 3: e.g., Delay in appropriate treatment will likely lead to emergency hospitalization]

For these reasons, I request an immediate exception to the step therapy requirement and approval for [Requested Drug]. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]