[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]
Policy Number: [Policy ID]
Group Number: [Group ID]
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 the step therapy requirements for the medication **[Requested Medication Name]**. [Patient Name] has been under my care for the management of **[Diagnosis, e.g., Type 2 Diabetes Mellitus, ICD-10 Code]** since [Date].

Currently, the patient's clinical status is as follows: [Recent A1c level, fasting glucose, or specific complications].

The health plan's step therapy protocol requires the trial and failure of the following preferred agents: [List Required Medications]. However, I am requesting an exception based on the following clinical rationale:

- **Contraindications:** The patient has a documented contraindication to [Preferred Medication] due to [Specific Medical Reason, e.g., Renal Impairment, History of Pancreatitis].
- **Previous Treatment Failure:** The patient has previously trialed [Preferred Medication] from [Start Date] to [End Date]. This treatment was ineffective in achieving glycemic targets or resulted in [Specific Adverse Reaction/Side Effect].
- **Clinical Stability:** The patient is currently stabilized on [Requested Medication Name]. Switching to a different agent poses a significant risk of hyperglycemia, hypoglycemia, or [Other Clinical Risk].

In my professional medical opinion, **[Requested Medication Name]** is medically necessary for this patient. Requiring the patient to trial the preferred alternatives would likely result in an adverse clinical outcome or significant delay in effective treatment.

Please find the attached medical records, lab results, and documentation supporting this request. I ask that you approve this exception immediately to ensure continuity of care.

Sincerely,

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