[Date]

[Health Plan Name]
[Appeals/Pharmacy Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Step Therapy Exception

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

Dear Medical Director,

I am writing to formally request a step therapy exception for my patient, **[Patient Name]**, for the use of **[Requested Targeted Therapy Drug Name]**. This medication is medically necessary for the treatment of **[Specific Cancer Diagnosis and ICD-10 Code]**.

Clinical Justification:
The patient's tumor expresses the **[Specific Biomarker/Genetic Mutation]** as confirmed by **[Type of Test, e.g., NGS or IHC]** on **[Date]**. Based on clinical evidence and NCCN Guidelines, **[Requested Drug]** is the most appropriate targeted therapy for this molecular profile.

Reason for Step Therapy Exception (Select applicable):

- The required preferred drug(s), **[List Preferred Drugs]**, are expected to be ineffective based on the patient's specific biomarker profile.
- The patient has already tried and failed the preferred drug(s) **[List Drugs]** from **[Start Date]** to **[End Date]** due to **[Disease Progression/Intolerable Toxicity]**.
- The preferred drug(s) are contraindicated for this patient due to **[List Co-morbidities or Drug Interactions]**.
- Delaying treatment with the requested targeted therapy to trial ineffective agents would cause irreversible clinical deterioration or permanent damage to the patient.

Proposed Treatment Plan:
I am prescribing **[Requested Drug]** at a dose of **[Dose]** every **[Frequency]**. I have attached the following supporting documentation:

- Pathology and Biomarker/Genomic Testing Reports
- Relevant Clinical Progress Notes
- Relevant Imaging/Scan Results
- Peer-reviewed Literature/NCCN Guidelines supporting this use

Given the aggressive nature of this malignancy, I request an expedited review of this request. Please contact my office at **[Phone Number]** if further information is required.

Sincerely,

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