

Date: [Date]

To: [Insurance Company Name]

Attention: [Appeals/Prior Authorization Department]

Fax Number: [Fax Number]

RE: Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy ID Number: [Policy 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 expedited exception to the step therapy requirements for [Requested Medication]. My patient has been diagnosed with [Primary Diagnosis/ICD-10 Code] and has been suffering from chronic pain for [Duration].

Based on the patient's medical history and clinical presentation, the required step therapy protocol is medically inappropriate for the following reasons:

- **Previous Treatment Failure:** The patient has already tried and failed the following preferred medications: [List Meds and Dates/Results].
- **Risk of Adverse Reaction:** The required medication(s) [Name of Step Therapy Drug] are contraindicated for this patient due to [Specific Medical Reason/Comorbidity].
- **Clinical Stability:** The patient is currently stabilized on [Requested Medication]. Switching medications poses a high risk of significant physical harm or relapse of pain management.

The patient's current symptoms include [List Symptoms]. Without access to [Requested Medication], the patient's condition is likely to worsen, leading to increased functional impairment and potential emergency care.

I am requesting an immediate approval for [Requested Medication] for a period of [Duration]. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Clinic Name]

[NPI Number]