

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Prior Authorization/Appeals Department

**FAX:** [Insurance Fax Number]

**RE:** Letter of Medical Necessity for Step Therapy Exception

**Patient Name:** [Patient Name]

**Date of Birth:** [Patient DOB]

**Policy ID:** [Member ID Number]

**Claim/Reference #:** [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 the treatment of hypertension. I am prescribing **[Requested Medication Name, Strength, and Dosage]**.

The patient's current diagnosis is **[ICD-10 Code and Description, e.g., I10 Essential Hypertension]**. I have determined that the plan-preferred medications required by step therapy are medically inappropriate for this patient based on the following clinical history:

- **Failed Medications:** The patient has previously tried and failed [List failed drugs, e.g., Lisinopril, Hydrochlorothiazide] due to [Lack of efficacy/uncontrolled BP].
- **Contraindications:** The patient has a documented contraindication to [Plan-preferred drug] due to [Specific condition/comorbidity].
- **Adverse Reactions:** The patient experienced [Describe side effects, e.g., severe cough, angioedema, electrolyte imbalance] while taking [Plan-preferred drug].
- **Clinical Stability:** The patient is currently stable on [Requested Medication], and switching to a preferred agent poses a significant risk of rebound hypertension or cardiovascular complications.

The requested medication, [Requested Medication], is essential to achieving the patient's target blood pressure of [Target BP, e.g.,

Please approve this exception for the requested treatment. If you require additional clinical documentation or have questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

**NPI Number:** [NPI Number]

**Clinic Name:** [Clinic Name]

**Phone:** [Phone Number]