[Date]
[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Step Therapy Override Exception Request
Patient Name: [Patient Name]
Member ID: [Member ID Number]
Group Number: [Group Number]
Date of Birth: [Date of Birth]
Case Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally appeal the requirement for step therapy regarding the medication [Requested Medication Name] prescribed for [Patient Name] for the treatment of [Diagnosis/Condition].

I am requesting a step therapy override based on the following clinical grounds:

- **Failed Previous Medications:** The patient has already tried and failed the required "step" medications: [List names of failed drugs]. These were ineffective or caused adverse reactions including [List specific side effects or lack of efficacy].
- **Medical Contraindication:** The required formulary medications are contraindicated for this patient because [Reason, e.g., drug interactions, comorbid conditions].
- **Clinical Instability:** The patient is currently stable on [Requested Medication Name]. Forcing a change in medication would cause clinical instability and significant health risks.
- **Urgency:** Delaying access to this specific treatment will result in [List potential health consequences].

Attached you will find supporting documentation, including medical records, previous prescriptions, and relevant clinical trial data that justify the necessity of [Requested Medication Name].

I request an expedited review of this appeal. Please notify me and the patient of your decision via phone or fax at [Physician Phone/Fax Number].

Sincerely,

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