[Date]

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

RE: Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID Number: [ID Number]
Claim/Reference Number: [Reference Number]

To Whom It May Concern:

I am writing to formally appeal the denial of coverage for [Requested Medication Name] for the treatment of [Diagnosis/Condition]. The denial was based on step therapy requirements requesting trial and failure of [Plan Required Medication(s)].

This appeal is based on the fact that [Patient Name] has already attempted and failed treatment with the required medication(s). Below is the clinical history regarding these prior treatments:

- **Required Medication:** [Drug Name 1]
  - Dates of Treatment: [Start Date] to [End Date]
  - Reason for Failure: [e.g., Inadequate response, worsening symptoms, or specific side effects]
- **Required Medication:** [Drug Name 2]
  - Dates of Treatment: [Start Date] to [End Date]
  - Reason for Failure: [e.g., Inadequate response, worsening symptoms, or specific side effects]

Because the patient has already undergone the "steps" required by the plan without clinical success, requiring a repeat trial of these medications would delay necessary care and pose a risk to the patient's health. [Requested Medication Name] is medically necessary to stabilize the patient's condition.

Attached please find supporting documentation, including [list attachments, e.g., clinical notes, pharmacy records, or lab results].

I request an immediate reversal of this denial. If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Name]
[Physician NPI Number]
[Practice Name]