[Date]

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

RE: Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim Number: [Claim Number, if applicable]

To Whom It May Concern,

I am writing to formally request an expedited exception to the step therapy requirements for [Name of Requested Medication]. My patient, [Patient Name], is currently diagnosed with [Diagnosis/ICD Code].

The standard step therapy protocol requires the use of [Name of Required Step Therapy Drug(s)]. However, this requirement should be waived because the patient has already experienced a documented adverse reaction to the preferred medication(s).

Clinical Justification:

- **Medication Attempted:** [Name of Drug]
- **Date(s) of Trial:** [Start Date] to [End Date]
- **Nature of Adverse Reaction:** [Detailed description of reaction, e.g., severe allergic response, toxicity, or intolerable side effects].

Due to this previous adverse reaction, it is medically contraindicated for the patient to repeat a trial of the preferred agent(s). Switching to or restarting the required step therapy drug poses a significant risk to the patient's health and safety. [Name of Requested Medication] is medically necessary for the effective treatment of the patient's condition.

Attached please find supporting medical records and documentation regarding the adverse event. I request that you approve coverage for [Name of Requested Medication] immediately.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Phone Number]