URGENT: TIME SENSITIVE STEP THERAPY EXEMPTION REQUEST

Date: [Date]

TO: [Insurance Company Name]
ATTN: Appeals/Prior Authorization Department
Fax Number: [Fax Number]

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

Dear Medical Director,

I am writing to formally request an immediate expedited exemption from step therapy requirements for my patient, [Patient Name], regarding the medication [Requested Medication Name].

Clinical Justification:
The patient has been diagnosed with [Diagnosis/ICD-10 Code]. Requiring the patient to trial and fail the preferred formulary agents [Name of Step Therapy Drugs] is medically inappropriate and poses a significant risk to the patient's health for the following reason(s):

- The required drug(s) is contraindicated for this patient due to [Reason].
- The patient has previously trialed [Name of Drug] from [Start Date] to [End Date] and experienced [Specific Adverse Reaction/Failure to Progress].
- Delaying treatment with [Requested Medication Name] will result in rapid clinical deterioration or [Specific Emergency Risk].
- The patient is currently stable on [Requested Medication Name] and a switch would cause a significant medical setback.

Provider Recommendation:
Based on the patient's medical history and the severity of their condition, [Requested Medication Name] is medically necessary. A delay in the initiation of this specific therapy constitutes a serious threat to the patient's life or health.

I request a decision within [24/72] hours as per the time-sensitive nature of this condition. Please contact my office at [Phone Number] or via fax at [Fax Number] with your determination.

Sincerely,

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

[NPI Number]
[Phone Number]