[Physician's Letterhead]

Date: [Date]

To: [Insurance Company Name / Pharmacy Benefit Manager]
Attn: Appeals/Medical Review Department
Fax Number: [Fax Number]

RE: Request for Protocol Override / Clinical Attestation
Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally request a protocol override and attestation for the medical necessity of **[Requested Medication/Procedure]** for my patient, **[Patient Name]**. This request is based on the patient's clinical history and the failure of required step-therapy protocols.

Diagnosis: [Primary Diagnosis Code and Description]

Clinical Justification for Override:
The patient has previously attempted and failed the following plan-preferred treatments:

- [Drug/Treatment A]: [Dates of Use] - Result: [Ineffective / Adverse Reaction]
- [Drug/Treatment B]: [Dates of Use] - Result: [Ineffective / Adverse Reaction]

Attestation:
I attest that the preferred formulary alternatives are medically inappropriate for this patient because: [Provide specific reason, e.g., contraindication, potential for severe drug interaction, or specialized clinical need].

Delaying treatment with **[Requested Medication/Procedure]** poses a significant risk to the patient's health, including [List potential complications]. Based on my professional clinical judgment and the patient's unique medical profile, I request an immediate override of the standard protocol.

Should you require additional documentation or clinical notes, please contact my office at [Phone Number]. Thank you for your prompt attention to this urgent medical matter.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[NPI Number]
[Medical Specialty]
[Clinic Name]