[Date]

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

RE: Urgent Expedited Appeal for [Patient Name]
Policy Number: [Policy ID]
Group Number: [Group ID]
Claim/Reference Number: [Reference Number]
Prescribed Medication: [Name of Requested Medication]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for [Requested Medication] for my patient, [Patient Name]. This appeal is based on the patient's clinical deterioration and the failure of required step therapy protocols.

The patient is diagnosed with [Diagnosis/ICD-10 Code]. According to your step therapy guidelines, the patient was required to try and fail [Name of Step Therapy Drug(s)]. The patient attempted these treatments from [Start Date] to [End Date].

During the step therapy period, the patient's condition worsened significantly, as evidenced by:

- [List specific clinical markers of deterioration, e.g., increased pain, lab results, or imaging]
- [List new or worsening symptoms]
- [List loss of functional status or hospitalization risks]

Strict adherence to the step therapy protocol is no longer medically appropriate and poses a serious threat to the patient's health. [Requested Medication] is medically necessary because it targets [Specific Mechanism] which the previous medications failed to address. Delaying access to this treatment will likely result in irreversible physical harm or further emergency interventions.

I have attached [Medical Records/Test Results/Clinical Notes] supporting this request. Given the patient's declining status, I request an expedited review of this appeal.

Thank you for your immediate attention to this matter.

Sincerely,

[Physician Name]
[Medical Specialty]
[Practice Name]
[Phone Number]