Date: [Date]

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

RE: Exception Request for Step Therapy Override

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

Dear Medical Director,

I am writing to formally request a step therapy override for **[Name of Requested Specialty Medication]** for my patient, **[Patient Name]**, who has been diagnosed with **[Diagnosis/ICD-10 Code]**.

The patient's current treatment plan requires this specific medication because the required step therapy protocol (the "fail-first" medications) is clinically inappropriate for the following reason(s):

- **Previous Treatment Failure:** The patient has already tried and failed the following preferred medications: [List Meds and Dates/Results].
- **Contraindication:** The preferred medication(s) are contraindicated for this patient due to [Reason/Medical Comorbidity].
- **Clinical Instability:** The patient is currently stable on the requested medication and switching would cause a significant risk of relapse or adverse medical events.
- **Expected Ineffectiveness:** Based on the patient's clinical profile, the preferred medication is expected to be ineffective.

Clinical Justification:
[Briefly describe the patient's medical history, severity of symptoms, and why the requested specialty drug is the most appropriate course of action.]

Attached please find clinical notes, lab results, and relevant medical records supporting this request. Given the specialty nature of this condition, I request an expedited review to ensure there is no interruption in the patient's care.

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require further information.

Sincerely,

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