[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Member ID Number]

[Date]

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

RE: Final Level Formal Grievance - Step Therapy Exception Request

Patient Name: [Patient Name]
Claim/Reference Number: [Reference Number]
Prescribed Medication: [Name of Drug]
Required Step Therapy Drugs: [Names of Failed Drugs]

Dear Appeals Committee,

I am writing to formally request a Final Level Review of the denial for the medication [Name of Drug]. This request is based on the medical necessity of this specific treatment and the clinical failure or contraindication of the plan-preferred alternatives required by your step therapy protocol.

I have already attempted the following required medications as part of the step therapy process:

- [Drug Name 1]: [Dates used] - Resulted in [Side effect/Inadequate response].
- [Drug Name 2]: [Dates used] - Resulted in [Side effect/Inadequate response].

My prescribing physician, Dr. [Doctor's Name], has determined that further adherence to the step therapy protocol poses a significant risk to my health. Specifically, [Briefly describe medical reason why other drugs will not work or are dangerous].

Attached you will find supporting documentation, including my medical records and a formal Letter of Medical Necessity from my physician. As this is the final level of internal grievance, I request an immediate reversal of the prior denial to prevent the progression of my condition.

Please provide a written determination regarding this final appeal within the timeframe mandated by state and federal law.

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: Letter of Medical Necessity, Clinical Notes, Previous Denial Letters