**[Date]**

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

**RE: Step Therapy Override Exception Request / Formal Appeal**

**Patient Name:** [Patient Name]
**Subscriber ID:** [ID Number]
**Group Number:** [Group Number]
**Date of Birth:** [DOB]
**Claim/Reference Number:** [Reference Number from Denial Letter]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for **[Name of Prescribed Medication]**. The denial was based on step therapy requirements requesting the use of **[Name of Required Step Medications]** before the prescribed medication can be approved.

As the prescribing physician, I am requesting a step therapy override and an immediate formulary exception for this patient based on the following clinical grounds:

- **Previous Treatment Failure:** The patient has already tried and failed the following required medications: [List Meds and Dates/Durations]. These treatments were ineffective in managing the patient's condition.
- **Contraindication:** The preferred formulary medications are contraindicated for this patient because [Reason: e.g., drug interaction, underlying condition, or history of adverse reaction].
- **Clinical Stability:** The patient is currently stabilized on [Prescribed Medication]. Forcing a switch to a different medication poses a significant risk of [Description of medical risk or relapse].
- **Medical Necessity:** Based on the patient's medical history and the severity of [Diagnosis/Condition], [Prescribed Medication] is the most appropriate treatment to prevent [Specific complications].

I have attached supporting clinical documentation, including [mention office notes, lab results, or peer-reviewed literature], to support this request. Please expedite this review to ensure there is no interruption in the patient's care.

I look forward to your prompt response regarding this override. If you require additional information, please contact my office at [Phone Number].

Sincerely,

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