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

[Date]

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

RE: Patient Name: [Patient Name]
Member ID Number: [ID Number]
Claim/Reference Number: [Reference Number]
Requested Medication: [Name of Prescribed Medication]

Dear Appeals Department,

I am writing to formally appeal the denial of coverage for [Name of Prescribed Medication], which was prescribed by my physician, [Physician Name], for the treatment of [Diagnosis/Condition]. My request was denied based on your step therapy protocol.

I am requesting an exception to this protocol for the following reason(s):

- I have already tried the required preferred medication(s), [Name of Preferred Drugs], and they were ineffective in treating my condition.
- The required preferred medication(s) caused the following adverse reactions/side effects: [Description of Side Effects].
- My physician has determined that the required preferred medication is expected to be ineffective based on my medical history and the known characteristics of the drug.
- I am currently stable on [Prescribed Medication], and switching to a different drug would pose a significant risk to my health.

Enclosed is a letter of medical necessity from my physician, along with supporting medical records and documentation of my previous treatments.

Please review this appeal and provide a written response within [Number of Days, e.g., 30] days. If you require further information, please contact me at [Phone Number] or my physician's office at [Physician Phone Number].

Sincerely,

[Your Signature]
[Your Printed Name]

Enclosures: Letter of Medical Necessity, Medical Records, Previous Prescriptions