Date: [Date]

To: [Insurance Company Name]
Attention: [Appeals/Prior Authorization Department]
Fax/Address: [Fax Number or Address]

RE: Exception Request for Step Therapy Protocols

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy ID Number: [Member ID]
Group Number: [Group Number]
Requested Medication: [Drug Name and Dosage]

To Whom It May Concern,

I am writing to request a step therapy exception for my patient, [Patient Name], who is currently under my care for [Diagnosis/Condition]. I am requesting coverage for [Requested Medication] because the formulary-preferred medication(s) required by the step therapy protocol have caused a documented adverse reaction.

Required Medication(s) Attempted: [Name of Preferred Drug(s)]
Dates of Trial: [Start Date] to [End Date]

Clinical Justification:
During the trial of the preferred medication, the patient experienced the following adverse reaction(s): [Detail specific side effects, allergic reactions, or physiological complications].

Due to this adverse reaction, continuing or restarting the preferred medication is medically contraindicated and poses a significant risk to the patient's health. [Requested Medication] is medically necessary for this patient as it is expected to be effective without the same risk of adverse reactions.

I have attached supporting clinical documentation, including [mention office notes, lab results, or allergy reports], detailing the patient's reaction.

Please expedite this request to ensure the patient receives appropriate treatment without further delay. If you have questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Phone/Fax Number]