Date: [Date]

To: [Health Insurance Company Name]
Attn: [Prior Authorization/Appeals Department]
Address: [Insurance Company Address]
Fax Number: [Fax Number]

RE: Prior Authorization Request for Step Therapy Exception

Patient Name: [Patient Name]
Date of Birth: [Date of Birth]
Member ID: [Member ID Number]
Group Number: [Group Number]
Requested Medication: [Name of Requested Medication]

Dear Medical Director,

I am writing to request a step therapy exception and prior authorization for [Requested Medication] for my patient, [Patient Name]. This patient has been diagnosed with [Diagnosis/ICD-10 Code] and has already failed the preferred medications required by your plan's step therapy protocols.

Required Medications Previously Attempted:

- **Failed Medication 1:** [Name of Drug]
    - Dates of Treatment: [Start Date] to [End Date]
    - Reason for Failure: [Inadequate response / Adverse reaction / Contraindication]
- **Failed Medication 2:** [Name of Drug]
    - Dates of Treatment: [Start Date] to [End Date]
    - Reason for Failure: [Inadequate response / Adverse reaction / Contraindication]

Clinical Justification:
Based on the patient's medical history and the failure of the medications listed above, I have determined that [Requested Medication] is medically necessary. Continuing the step therapy protocol would likely result in [expected negative clinical outcome or prolonged suffering].

Attached you will find [List supporting documents, e.g., clinical notes, lab results, or pharmacy records] confirming these treatment failures.

I request that you approve this authorization immediately to ensure the patient receives the necessary standard of care. Please contact my office at [Phone Number] if further information is required.

Sincerely,

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