Date: [Date]

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

RE: Step Therapy Exception Request / Clinical Contraindication

Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]

Dear Medical Director,

I am writing to request an exception to the step therapy requirement for **[Name of Requested Medication]** for my patient, **[Patient Name]**. The required formulary alternative(s), **[Name of Required/Failed Drugs]**, is/are clinically contraindicated for this patient.

Diagnosis: [ICD-10 Code and Description]

Reason for Clinical Contraindication:

[Insert detailed explanation here. Examples include:

- Known allergy to an ingredient in the required drug.
- Documented history of adverse reaction to a similar drug class.
- Potential for life-threatening drug-drug interaction with current medications (List: [Medications]).
- Comorbid condition that prohibits the use of the required drug (e.g., Renal failure, Liver disease).
- The required drug is expected to cause a significant decrease in the patient's physical or mental capability.

]

Clinical Justification:
Based on the patient's medical history and the specific contraindications mentioned above, bypassing the step therapy protocol is medically necessary to avoid significant harm or ineffective treatment. **[Name of Requested Medication]** is the most appropriate clinical choice for this patient at this time.

I have attached relevant medical records and supporting documentation for your review. Please expedite this request to ensure the patient receives timely treatment.

Sincerely,

[Physician Signature]
Physician Name: [Name]
NPI Number: [NPI Number]
Phone: [Phone Number]
Practice Name: [Practice Name]