

Date: [Date]

To: [Health Insurance Company Name]

Attention: Utilization Management/Appeals Department

Address: [Insurance Company Address]

Fax Number: [Fax Number]

RE: Continuity of Care Exception Request / Step Therapy Override

Patient Name: [Patient Name]

Date of Birth: [Patient DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

Prescribed Medication: [Drug Name, Dosage, and Frequency]

To Whom It May Concern,

I am writing to request a continuity of care exception and a step therapy override for my patient, [Patient Name], who is currently under my care for [Diagnosis/Condition].

The patient has been stable on [Drug Name] since [Date Treatment Started]. This medication was previously covered under the patient's prior insurance plan ([Previous Insurance Name]). A transition to the formulary-preferred medication(s), [Name of Preferred Drugs], would pose a significant risk to the patient's health and clinical stability.

Clinical Justification:

- The patient has achieved clinical stability/remission on the current medication.
- Switching medications at this time may result in [mention risks, e.g., relapse, severe side effects, or hospitalization].
- [Optional: Mention any previous failed trials of the insurer's preferred drugs].

Based on the patient's positive response to the current treatment and the medical necessity of maintaining stability, I request that you authorize continued coverage for [Drug Name] without requiring the completion of step therapy protocols.

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require additional medical records or information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone/Fax Number]