

**Date:** [Date]

**To:** [Health Plan Name]

**Attention:** Utilization Management Department

**Fax Number:** [Fax Number]

**RE: Step Therapy Exception Request - Expected Clinical Harm**

**Patient Name:** [Patient Name]

**Date of Birth:** [Patient DOB]

**Member ID:** [Member ID Number]

**Provider Name:** [Physician Name]

To Whom It May Concern,

I am writing to formally request an exception to the step therapy protocol for my patient, [Patient Name], regarding the medication [**Requested Medication Name**].

As the treating physician, it is my clinical opinion that requiring the patient to trial the plan-mandated preferred drug(s), [**Preferred Drug Name(s)**], will likely result in clinical harm or a decrease in the patient's physical or mental capability.

**Clinical Rationale for Exception:**

- The patient has a documented contraindication to the preferred medication(s).
- The preferred medication is expected to cause a significant adverse drug reaction or physical harm based on the patient's medical history.
- The patient is currently stable on [Requested Medication Name], and switching medications poses a high risk of relapse or acute medical emergency.
- [Insert specific clinical details or comorbidities here].

Based on these medical factors, I request that you waive the step therapy requirement and provide immediate coverage for [Requested Medication Name].

Please contact my office at [Phone Number] if you require additional medical records or clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic Name]