URGENT MEDICAL NECESSITY: STEP THERAPY EXCEPTION REQUEST

Date: [Date]

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

Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Policy ID Number: [ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number, if applicable]

Prescribed Medication: [Name of Requested Medication]
Required Step Therapy Medication(s): [Name of Required Drugs]

Dear Medical Director,

I am writing to request an urgent expedited exception to the step therapy requirements for [Patient Name]. As their treating physician, I have determined that the required step therapy protocol is medically inappropriate for this patient and that immediate access to [Requested Medication] is necessary to prevent serious jeopardy to the patient's life or health.

Clinical Justification:

[Insert brief clinical summary including diagnosis and current symptoms.]

Reason for Exception (Check all that apply):

- The required drug is contraindicated or will likely cause an adverse reaction.
- The required drug is expected to be ineffective based on the patient's clinical characteristics.
- The patient has already tried the required drug(s) and treatment was discontinued due to lack of efficacy or adverse events.
- The patient is currently stable on the requested medication, and switching may cause clinical harm.
- Delaying treatment with the requested medication poses an immediate threat to the patient's health.

Previous Treatments:

[List previous medications tried, dates of use, and specific reasons for failure or intolerance.]

Based on the clinical urgency of this case, I request an expedited review and approval of this exception within [24/48/72] hours as required by state/federal regulations. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Clinic/Facility Name]