Date: [Date]

To: [Insurance Company Name]
Attn: Medical Review/Prior Authorization Department
Fax/Address: [Fax Number or Mailing Address]

RE: Prior Authorization Request for Step Therapy Exception

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

Dear Medical Review Department,

I am writing to request a step therapy exception for my patient, **[Patient Name]**, who is currently under my care for the management of **[Name of Chronic Condition]** (ICD-10 code: [Code]). I am requesting coverage for **[Requested Medication Name]** at a dosage of **[Dosage]**.

The patient's current clinical status requires this specific medication because:

- **Failed Previous Therapies:** The patient has already tried and failed the following plan-preferred medications: [List Meds] due to [Lack of Efficacy/Side Effects].
- **Risk of Clinical Deterioration:** Requiring the patient to try [Name of Preferred Medication] would likely result in a significant delay in effective treatment, potentially leading to irreversible progression of their chronic condition.
- **Clinical Contraindications:** The plan-preferred medication is contraindicated for this patient due to [Specific Medical Reason/Drug Interaction].

Based on the patient's long-term medical history and the chronic nature of this illness, **[Requested Medication Name]** is medically necessary to maintain stability and prevent hospitalization or disability.

I have attached supporting clinical documentation, including recent lab results and office notes, for your review. Please contact my office at **[Phone Number]** if further information is required.

Sincerely,

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