

Date: [Date]

TO: [Health Insurance Company Name]
ATTN: Appeals/Medical Review Department
Fax Number: [Fax Number]

RE: Exception Request for Step Therapy (Prior Authorization)

Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case/Reference Number: [Reference Number if applicable]

Dear Medical Director,

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

Diagnosis: [Specific Pediatric Diagnosis/ICD-10 Code]
Requested Medication: [Medication Name, Dosage, and Frequency]

The required step therapy protocol mandates the use of [Name of Required "Step" Medications] before [Requested Medication] can be approved. I am requesting an exception based on the following clinical grounds:

- **Contraindication:** The required medication(s) are contraindicated for this patient because [Reason: e.g., age-appropriateness, existing comorbidities, or drug interactions].
- **Previous Failure:** The patient has already attempted a trial of [Failed Medication Name] from [Start Date] to [End Date]. This treatment was ineffective or resulted in an adverse reaction consisting of [Describe Side Effects].
- **Clinical Instability:** The patient is currently stable on [Requested Medication]. Switching to the preferred alternative would pose a significant risk of clinical regression or physical harm.
- **Pediatric Specificity:** The required alternative lacks FDA approval or established safety data for this patient's specific pediatric age group, whereas [Requested Medication] is the standard of care.

In my professional medical opinion, requiring this pediatric patient to follow the standard step therapy protocol will result in a delay of necessary treatment and potentially lead to preventable worsening of their condition.

I have attached [List attachments: e.g., clinical notes, lab results, or peer-reviewed journals] to support this request. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice/Clinic Name]

[NPI Number]