

Date: [Date]

TO: [Insurance Company Name]

ATTN: Pharmacy Benefits/Appeals Department

Fax Number: [Fax Number]

RE: Authorization Request for [Patient Name]

Date of Birth: [Patient DOB]

Member ID: [Member ID Number]

Provider Tax ID: [Tax ID]

To Whom It May Concern,

I am writing to request a step therapy exception and immediate authorization for the following medication: **[Requested Medication Name, Dosage, and Frequency]**. This medication is medically necessary for the treatment of **[Diagnosis/ICD-10 Code]**.

The patient has previously attempted and failed the following preferred formulary medications:

- **Medication 1:** [Name] | **Duration:** [Dates] | **Reason for Failure:** [e.g., Lack of efficacy, adverse side effects]
- **Medication 2:** [Name] | **Duration:** [Dates] | **Reason for Failure:** [e.g., Contraindicated due to specific comorbidity]

Clinical Justification:

The patient's psychiatric condition is currently [stable/unstable]. Requiring the patient to trial additional formulary alternatives would likely result in: [e.g., significant clinical decline, hospitalization, or severe adverse reactions]. Based on the patient's clinical history and the pharmacological profile of [Requested Medication], it is my professional opinion that this treatment is the most appropriate option.

Please expedite this request to ensure continuity of care and prevent symptom relapse.

Sincerely,

[Physician Name, Credentials]

[Practice Name]

[Phone Number]

[Email Address]