Date: [Date]

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

RE: Urgent Request for Step Therapy Exception and Formulary Tier Reduction

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Insurance Member ID]
Group Number: [Group Number]
Requested Medication: [Prescribed Drug Name and Dosage]

Dear Medical Director,

I am writing to formally request a **Step Therapy Exception** and a **Formulary Tier Reduction** for the medication listed above. This medication is medically necessary for the treatment of [Diagnosis/ICD-10 Code].

Step Therapy Exception Justification:
The patient has previously tried and failed the following formulary-preferred alternatives:

- [Drug Name 1]: Failed due to [Reason: Lack of efficacy / Adverse reaction]
- [Drug Name 2]: Failed due to [Reason: Lack of efficacy / Adverse reaction]

Other preferred alternatives are contraindicated for this patient because [State clinical reason/comorbidities]. Requiring the patient to follow the standard step therapy protocol would likely result in [Clinical worsening/emergency].

Tier Reduction Justification:
I am also requesting that this medication be covered at the [Preferred Brand/Lower Tier] cost-sharing level. The requested drug is the most clinically appropriate treatment for this patient, and there is no alternative drug on a lower tier that is as effective or has as few side effects for this specific patient's profile.

Included with this letter are [Clinical notes/lab results/history of failed trials] to support this request. Please expedite this review to ensure the patient does not experience a gap in care.

Sincerely,

[Physician Signature]
Physician Name: [Provider Name]
NPI Number: [NPI Number]

Phone Number: [Office Phone]
Fax Number: [Office Fax]