

[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]

[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Re: Request for Step Therapy Authorization

Patient: [Patient's Name]

Policy Number: [Patient's Policy Number]

Claim Number: [Claim Number, if available]

Dear [Insurance Company Representative's Name or "To Whom It May Concern"],

I am writing to formally request an exception to the step therapy protocol in relation to my prescription for [Medication Name]. My healthcare provider, [Provider's Name], has determined that this medication is medically necessary for my treatment.

[Briefly explain the medical condition and why the prescribed medication is essential. Include any previous medications attempted and their outcomes if applicable.]

Attached, you will find relevant medical documentation supporting this request, including:

1. A letter from my healthcare provider outlining the necessity of the requested medication.
2. Medical records that detail my treatment history.
3. Any relevant lab results or diagnostic imaging reports.

I appreciate your consideration of this request and am hopeful for a prompt resolution. If additional information is required, please do not hesitate to contact me directly at [Your Phone Number] or [Your Email Address].

Thank you for your attention to this matter.

Sincerely,

[Your Name]
[Your Title, if applicable]
[Your Relationship to Patient, if applicable]
[Attachments: Medical Documentation]