Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization/Appeals Department
FAX: [Fax Number]

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

To Whom It May Concern,

I am writing to request a formal coverage authorization for a compounded version of **[Medication Name]** that is **dye-free**. I have determined that this compounded medication is medically necessary for [Patient Name] due to a documented sensitivity/allergy to synthetic dyes and additives found in commercially available versions of this drug.

Clinical Justification:
The patient has a confirmed diagnosis of [Diagnosis/Condition]. The patient has experienced the following adverse reactions when using standard medications containing dyes: [List symptoms, e.g., urticaria, hyperactivity, GI distress, or anaphylaxis].

Reason for Compounding:
Currently, there are no FDA-approved, commercially manufactured alternatives for [Medication Name] that are free of [Specific Dye, e.g., Red 40, Yellow 5]. Therefore, a customized formulation from a compounding pharmacy is required to ensure patient safety and medication adherence.

Prescription Details:
[Insert Formulation Details, e.g., Drug Name, Strength, and "Dye-Free Oral Suspension"]

In summary, the use of a dye-free compounded medication is essential to avoid a significant allergic reaction and to treat the patient's underlying condition effectively. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

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