[Date]

[Health Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]
[Fax Number]

RE: Initial Prior Authorization Request for Specialty Infusion Therapy

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

To Whom It May Concern,

I am writing to request a prior authorization for **[Medication Name]** for the treatment of **[Diagnosis/ICD-10 Code]** for the above-referenced patient.

Clinical Justification:
The patient was diagnosed with [Condition] on [Date]. Current symptoms include [Symptoms]. To date, the patient has tried and failed the following therapies:

- [Previous Medication/Therapy 1] - Reason for failure: [e.g., Lack of efficacy/Side effects]
- [Previous Medication/Therapy 2] - Reason for failure: [e.g., Contraindication]

Treatment Plan:
Medication: [Medication Name]
Dose: [Dosage, e.g., 5mg/kg]
Frequency: [Frequency, e.g., Every 4 weeks]
Route of Administration: Intravenous Infusion
Requested Duration: [e.g., 12 months]
Place of Service: [e.g., Office, Infusion Center, or Home Health]

Attached please find supporting clinical documentation, including office notes, diagnostic test results, and relevant lab reports. Based on the patient's clinical history, this specialty infusion is medically necessary to prevent further disease progression.

Please contact my office at [Phone Number] or by fax at [Fax Number] if you require additional information. Thank you for your prompt review of this request.

Sincerely,

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