

URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST

Date: [Insert Date]

To: [Health Insurance Company Name]

Attention: Utilization Management / Pharmacy Department

Fax Number: [Insert Fax Number]

RE: Patient Information

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Member ID: [Insert Member ID]

Group Number: [Insert Group Number]

RE: Provider Information

Requesting Physician: [Insert Physician Name]

NPI Number: [Insert NPI Number]

Phone Number: [Insert Phone Number]

Fax Number: [Insert Fax Number]

RE: Medication & Treatment Clinical Summary

Requested Medication: [Insert Drug Name and HCPCS Code]

Dosage/Frequency: [Insert Dose and Schedule]

Diagnosis: [Insert ICD-10 Code and Description]

Place of Service: [Insert Home Infusion, Office, or Outpatient Clinic]

Expedited Review Justification:

I am requesting an expedited review because the standard 72-hour turnaround time could seriously jeopardize the patient's life, health, or ability to regain maximum function. [Briefly state clinical urgency, e.g., "Patient is experiencing acute flare-up" or "Delay will result in hospitalization"].

Clinical Documentation Attached:

- Physician Letter of Medical Necessity
- Clinical notes and physical assessment
- Relevant laboratory results and diagnostic tests
- History of failed therapies (Step Therapy documentation)

Please provide a determination via fax within 24 hours. If you have any questions, please contact our office immediately at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Practice Name]