DATE: [Date]

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

RE: Initial Prior Authorization Request

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

Provider Information:
Requesting Physician: [Physician Name]
NPI Number: [NPI Number]
Practice Name: [Practice Name]
Phone: [Phone Number]
Fax: [Fax Number]

Clinical Information:
Diagnosis: [Diagnosis Name]
ICD-10 Code: [ICD-10 Code]
Requested Medication: [Drug Name]
HCPCS Code: [J-Code]
Dosage/Frequency: [Dosage and Schedule]

To Whom It May Concern,

I am writing to request a prior authorization for the rheumatology specialty infusion therapy listed above for my patient. This treatment is medically necessary based on the patient's clinical presentation and diagnosis of [Diagnosis].

Clinical Justification:
The patient is currently experiencing [List symptoms/disease activity level]. Lab results indicate [Relevant lab values].

Treatment History:
The patient has previously tried and failed the following therapies:
1. [Drug Name] - Reason for failure: [e.g., Inefficacy/Side Effects] - Duration: [Dates]
2. [Drug Name] - Reason for failure: [e.g., Inefficacy/Side Effects] - Duration: [Dates]

Attached are the relevant medical records, clinical notes, and laboratory results supporting this request. Please contact our office if additional information is required.

Sincerely,

[Physician Signature]

[Physician Name]