

DATE: [Date]

TO: [Insurance Company Name]

ATTN: Prior Authorization Department

FAX: [Fax Number]

RE: Initial Prior Authorization Request for Oncology Infusion Therapy

PATIENT INFORMATION:

Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

PROVIDER INFORMATION:

Physician Name: [Doctor Name]

NPI Number: [NPI Number]

Facility Name: [Clinic/Hospital Name]

Tax ID: [Tax ID Number]

Contact Phone: [Phone Number]

CLINICAL INFORMATION:

Primary Diagnosis: [ICD-10 Code and Description]

Requested Medication: [Drug Name / HCPCS Code]

Dosage: [Amount/Frequency]

Expected Duration: [Length of Treatment]

Dear Medical Director,

This letter is to request a formal prior authorization for [Patient Name] to begin [Medication Name] for the treatment of [Diagnosis].

The patient has been diagnosed with [Stage/Type of Cancer]. Clinical rationale for this specialty infusion includes:

- [Clinical Reason 1: e.g., Patient is Stage IV]
- [Clinical Reason 2: e.g., Genetic marker status (PD-L1, BRAF, etc.)]
- [Clinical Reason 3: e.g., Failure of previous therapy or contraindication]

Attached you will find supporting documentation including:

- History and Physical (H&P) notes
- Pathology and Imaging reports
- Relevant laboratory results
- Current treatment plan and medication list

We request an expedited review as this is a time-sensitive oncology treatment. Please contact our office at [Phone Number] if you require additional information.

Sincerely,

[Physician Signature]

[Physician Printed Name]