Date: [Date]

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

RE: Initial Prior Authorization Request for Neurological Specialty Infusion

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member 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 **[Patient Name]**, who has been diagnosed with **[Diagnosis/ICD-10 Code]**.

Clinical Justification:
The patient presents with [Brief Description of Symptoms/Severity]. Based on clinical guidelines and the patient's neurological history, this specialty infusion is medically necessary to [Prevent Disease Progression / Manage Symptoms].

Treatment Plan:
- **Medication:** [Drug Name]
- **Dosage:** [Dosage Amount and Frequency]
- **Route of Administration:** Intravenous Infusion
- **Duration:** [Expected Length of Treatment]
- **Place of Service:** [Office/Infusion Center/Home Health]

Previous Therapies:
The patient has previously tried and failed the following treatments:

- [Previous Treatment 1]: [Dates] - [Reason for Failure]
- [Previous Treatment 2]: [Dates] - [Reason for Failure]

Attached please find supporting clinical notes, diagnostic test results, and laboratory reports for your review. If you require further information, please contact my office at [Phone Number].

Sincerely,

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