

Date: [Date]

To: [Insurance Company Name]

Attention: Prior Authorization Department / Medical Review

Fax Number: [Fax Number]

RE: Initial Prior Authorization Request

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

Dear Medical Director,

I am writing to request a formal prior authorization for gastrointestinal specialty infusion therapy for the above-referenced patient. I have determined that this medication is medically necessary based on the patient's clinical history and diagnosis.

Diagnosis Information:

- **ICD-10 Code:** [Insert Code, e.g., K50.90]
- **Description:** [Insert Diagnosis, e.g., Crohn's Disease / Ulcerative Colitis]
- **Severity:** [Moderate to Severe / Refractory]

Requested Medication and Treatment Plan:

- **Drug Name:** [Drug Name, e.g., Remicade, Stelara, Entyvio]
- **HPCS Code:** [Insert Code, e.g., J1745]
- **Dosage:** [Insert Dosage, e.g., 5mg/kg]
- **Frequency:** [Induction schedule and maintenance frequency]
- **Place of Service:** [Office / Infusion Center / Home]

Clinical Justification:

The patient has previously attempted and failed the following therapies: [List medications such as Mesalamine, Azathioprine, Corticosteroids, or other Biologics]. The patient is currently experiencing symptoms including [List symptoms: e.g., frequent bowel movements, abdominal pain, weight loss]. Current lab results indicate [Insert relevant lab values, e.g., elevated CRP or Calprotectin].

Attached please find the patient's recent clinical notes, diagnostic test results, and laboratory reports supporting this request.

Please contact my office at [Phone Number] should you require additional information. Thank you for your prompt attention to this matter.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone Number]