

Date: [Date]

TO: [Insurance Company Name]

ATTN: Prior Authorization/Utilization Management Department

FAX: [Fax Number]

PHONE: [Phone Number]

RE: Initial Prior Authorization Request for Intravenous Immunoglobulin (IVIG)

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

Policy Holder: [Name of Policy Holder]

Dear Medical Director,

I am writing to request a prior authorization for **Intravenous Immunoglobulin (IVIG)** therapy for the above-referenced patient. I have determined that this specialty infusion therapy is medically necessary based on the patient's clinical presentation and diagnosis.

Clinical Documentation:

- **Primary Diagnosis:** [ICD-10 Code and Description]
- **Relevant Medical History:** [Brief summary of symptoms and disease progression]
- **Laboratory Evidence:** [Summary of IgG levels, antibody titers, or biopsy results]
- **Previous Therapies:** [List failed treatments or contraindications to other therapies]

Treatment Plan:

- **Requested Medication:** [Specific Brand Name or J-Code]
- **Dosage:** [e.g., 2g/kg or specific grams]
- **Frequency:** [e.g., Every 3 or 4 weeks]
- **Duration:** [e.g., 6 months or 1 year]
- **Place of Service:** [Home Infusion / Office / Outpatient Hospital]

Attached please find the relevant clinical notes, laboratory reports, and diagnostic tests supporting this request. Failure to initiate this treatment may result in [mention potential complications, e.g., severe infection, neurological decline, or hospitalization].

Thank you for your prompt review of this request. Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone Number]

[Fax Number]