[Date]

[Payer Name]
[Payer Address]
[City, State, Zip Code]

RE: Prior Authorization Request for Biologic Specialty Infusion Therapy

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

To Whom It May Concern,

I am writing to request prior authorization for **[Name of Biologic Medication]** for the treatment of **[Patient's Diagnosis]** (ICD-10 Code: **[Code]**). My patient has been under my care since **[Date]** and requires this specialty infusion therapy to manage their condition effectively.

Clinical Justification:
The patient presents with **[List Symptoms/Severity]**. To date, the patient has attempted and failed the following conservative or first-line treatments:

- **[Previous Medication/Therapy 1]:** Tried from [Date] to [Date]. Result: [Inadequate response/Intolerance].
- **[Previous Medication/Therapy 2]:** Tried from [Date] to [Date]. Result: [Inadequate response/Intolerance].

Treatment Plan:
The proposed treatment plan for **[Name of Biologic Medication]** is as follows:

- **Dosage:** [Dosage Amount]
- **Frequency:** [Infusion Schedule, e.g., every 8 weeks]
- **Route of Administration:** Intravenous Infusion (Place of Service: [Office/Infusion Center])
- **Expected Duration:** [Length of Treatment]

Attached please find supporting clinical documentation, including office notes, relevant lab results, and diagnostic reports confirming the necessity of this therapy.

Please contact my office at **[Phone Number]** or by fax at **[Fax Number]** if further information is required for this authorization. Thank you for your prompt attention to this request.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]