DATE: [Date]

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

RE: Initial Prior Authorization Request for Infusion Therapy

PATIENT INFORMATION:
Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

PHYSICIAN INFORMATION:
Name: [Provider Name]
NPI: [Provider NPI]
Phone: [Phone Number]
Fax: [Fax Number]

DIAGNOSIS: [Diagnosis Name, e.g., Moderate to Severe Plaque Psoriasis]
ICD-10 CODE: [ICD-10 Code]

REQUESTED MEDICATION:
Drug Name: [Drug Name, e.g., Remicade, Stelara, Skyrizi]
HCPCS Code: [Code, e.g., J1745]
Dosage: [Dosage Amount]
Frequency: [Frequency/Interval]
Route: Intravenous Infusion
Place of Service: [Office / Infusion Center / Home]

CLINICAL JUSTIFICATION:
[Patient Name] presents with [Severity] [Diagnosis]. The patient has a Body Surface Area (BSA) involvement of [%]. Previous treatments including [List Prior Meds, e.g., Methotrexate, Topical Steroids, Phototherapy] have been unsuccessful or are contraindicated due to [Reason].

ATTACHMENTS INCLUDED:
1. Clinical Progress Notes
2. Relevant Lab Results
3. Documentation of Failed Conventional Therapies
4. Prescription / Order Form

Please contact our office at [Phone Number] if further information is required for approval.

Sincerely,

[Provider Signature]
[Provider Printed Name]