

**DATE:** [Date]

**TO:** [Insurance Company Name]

**ATTENTION:** Prior Authorization Department

**FAX:** [Fax Number]

**RE: Initial Prior Authorization Request for Hematological Infusion Therapy**

**PATIENT INFORMATION:**

Name: [Patient Full Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

**PRESCRIBER INFORMATION:**

Provider Name: [Provider Name]

NPI Number: [NPI Number]

Office Contact Name: [Contact Name]

Phone: [Phone Number]

Fax: [Fax Number]

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**CLINICAL INFORMATION:**

Diagnosis: [Primary Diagnosis Name]

ICD-10 Code: [ICD-10 Code]

Medication Requested: [Drug Name and Dose]

HCPCS Code: [Code, e.g., J-Code]

Frequency/Duration: [e.g., Every 4 weeks for 12 months]

Place of Service: [Office/Infusion Center/Home]

**MEDICAL NECESSITY JUSTIFICATION:**

[Patient Name] is a [Age]-year-old patient diagnosed with [Diagnosis]. This medication is medically necessary because:

- The patient has failed previous therapy with: [List previous drugs and dates].
- The patient has the following contraindications to standard therapies: [List contraindications].
- Clinical laboratory results supporting this diagnosis include: [List relevant labs, e.g., Hemoglobin, Platelets, Factor levels].

**ATTACHMENTS INCLUDED:**

- Clinical Progress Notes
- Relevant Laboratory Results
- FDA Approval / Peer-Reviewed Literature (if applicable)

Please review this request for medical necessity. If you require additional information, please contact our office at [Phone Number].

Sincerely,

[Provider Signature]

[Provider Printed Name]