

Date: [Date]

To: [Insurance Company Name]

Attention: Prior Authorization Department

Fax/Phone: [Fax/Phone Number]

RE: Pediatric Initial Prior Authorization Request

Patient Name: [Patient Name]

Date of Birth: [Patient Date of Birth]

Member ID: [Member ID Number]

Policy Number: [Policy Number]

Prescribing Provider: [Physician Name]

NPI Number: [NPI Number]

Clinic/Hospital: [Clinic Name]

Phone: [Phone Number]

Diagnosis: [Diagnosis Name]

ICD-10 Code: [ICD-10 Code]

Requested Medication/Therapy: [Medication Name]

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

Dosage: [Dose based on Weight/BSA]

Frequency: [Frequency]

Route of Administration: Intravenous Infusion

Place of Service: [Home / Outpatient Infusion Center / Hospital]

To Whom It May Concern,

I am writing to request a prior authorization for [Medication Name] for my pediatric patient, [Patient Name]. This patient has been diagnosed with [Diagnosis] and requires specialty infusion therapy to manage their condition and prevent disease progression.

Clinical Justification:

[Patient Name] is a [Age]-year-old weighing [Weight] kg. The patient has exhibited the following symptoms and clinical findings: [List key symptoms, lab results, or imaging]. Current standard-of-care treatments have been considered; however, [Medication Name] is medically necessary because [Reason why this specific drug is required].

Previous Therapies Attempted:

1. [Drug Name] - Dates: [Start/End] - Reason for failure/contraindication: [Reason]
2. [Drug Name] - Dates: [Start/End] - Reason for failure/contraindication: [Reason]

Attached are the clinical notes, relevant laboratory results, and the formal prescription for your review. Please expedite this request to ensure there is no delay in starting this essential pediatric treatment.

Should you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical Specialty]