[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]
[Fax Number]

RE: Initial Prior Authorization Request for Specialty Infusion Therapy

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
Case Reference Number: [Reference Number, if applicable]

Dear Medical Director,

I am writing to request a prior authorization for **[Name of Specialty Medication]** for my patient, **[Patient Name]**, who has been diagnosed with **[Name of Rare Disease]** (ICD-10 Code: [Code]).

Clinical Justification:
The patient presents with [list primary symptoms and disease progression]. Due to the rarity and severity of this condition, [Medication Name] is medically necessary to [prevent irreversible organ damage / manage life-threatening symptoms / improve functional status].

Treatment Plan:
The requested treatment regimen is [Dosage] administered via [Intravenous/Subcutaneous] infusion every [Number] weeks. The therapy will be administered at [Location: Home Infusion / Hospital Outpatient / Infusion Center].

Previous Therapies:
The patient has previously attempted the following treatments which were unsuccessful or contraindicated:

- [Therapy A]: [Outcome/Reason for failure]
- [Therapy B]: [Outcome/Reason for failure]

Attached please find the supporting clinical documentation, including laboratory results, diagnostic imaging, and relevant peer-reviewed literature regarding the efficacy of this therapy for [Rare Disease Name].

Please contact my office at [Phone Number] or via fax at [Fax Number] if you require additional information to expedite this urgent request.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Contact Email]