

Date: [Date]

TO: [Insurance Company Name]

ATTN: Prior Authorization Department

FAX: [Fax Number]

PHONE: [Phone Number]

RE: Initial Prior Authorization Request for Clinic-Administered Infusion Therapy

PATIENT INFORMATION:

Name: [Patient Name]

Date of Birth: [DOB]

Policy ID Number: [Policy ID]

Group Number: [Group Number]

PROVIDER INFORMATION:

Requesting Physician: [Physician Name]

NPI Number: [NPI Number]

Clinic/Facility Name: [Clinic Name]

Address: [Clinic Address]

Contact Person: [Name] | Phone: [Phone Number]

CLINICAL INFORMATION:

Primary Diagnosis: [Diagnosis Name]

ICD-10 Code: [ICD-10 Code]

Requested Medication: [Medication Name]

HCPCS Code: [J-Code]

Dosage: [Dosage, e.g., 5mg/kg]

Frequency: [Frequency, e.g., every 4 weeks]

Duration of Request: [e.g., 12 months]

MEDICAL NECESSITY JUSTIFICATION:

[Patient Name] has been diagnosed with [Diagnosis]. Clinical records indicate that the patient has previously tried and failed the following therapies:

- [Previous Medication 1]: [Date/Reason for Failure]
- [Previous Medication 2]: [Date/Reason for Failure]

The patient requires clinic-administered infusion therapy because [Reason: e.g., complexity of administration, monitoring requirements, or severity of disease].

ATTACHMENTS INCLUDED:

Clinical Progress Notes

Relevant Lab Results/Diagnostic Tests

Medication History/MAR

Letter of Medical Necessity

Please review this request for medical necessity. If you have any questions or require additional documentation, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]