Date: [Date]

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

RE: Initial Prior Authorization Request for External Insulin Pump
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Group Number: [Group Number]

Dear Medical Review Board,

I am writing to request a prior authorization for an external insulin infusion pump for my patient, [Patient Name], who has been diagnosed with [Type 1 / Type 2 Insulin-Requiring] Diabetes Mellitus (ICD-10: [Code]).

Clinical Justification:

- The patient currently requires multiple daily injections (MDI) of insulin.
- The patient performs blood glucose monitoring [Number] times per day.
- Despite adherence to current therapy, the patient experiences: [e.g., elevated HbA1c of %, frequent hypoglycemia, dawn phenomenon, or severe glycemic variability].
- The patient has completed diabetes self-management education and is capable of managing pump technology.

Requested Equipment:

- **Device:** [Brand/Model of Insulin Pump]
- **HCPCS Code:** E0784
- **Supplies:** Infusion sets (A4230/A4231) and Reservoirs (A4232)

I have attached the most recent clinical notes, lab results (HbA1c), and blood glucose logs to support this request. Continuous subcutaneous insulin infusion is medically necessary for this patient to achieve glycemic control and prevent long-term complications.

Please contact my office at [Phone Number] if further information is required.

Sincerely,

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