URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
CLINICAL INDICATOR: ONCOLOGY / CHEMOTHERAPY

Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department / Medical Director
Fax Number: [Fax Number]

RE: Patient Information
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]

Provider Information
Requesting Physician: [Physician Name]
NPI Number: [NPI Number]
Facility Name: [Facility Name]
Phone/Fax: [Phone/Fax Number]

Clinical Information
Diagnosis: [Primary Diagnosis and ICD-10 Code]
Requested Medication(s): [Drug Name(s) and HCPCS Codes]
Dosage/Frequency: [Dosage and Cycle Schedule]
Proposed Start Date: [Date]

To Whom It May Concern,

This is a formal request for an **expedited** prior authorization for the chemotherapy regimen listed above. This request is being made on an expedited basis because a delay in the commencement of treatment may seriously jeopardize the patient's life, health, or ability to regain maximum function.

Clinical Justification:
The patient has been diagnosed with [Stage/Type of Cancer]. Due to the aggressive nature of this malignancy and the patient's current clinical status ([Briefly mention symptoms or rapid progression]), immediate administration of [Drug Name] is medically necessary. Standard processing timeframes for prior authorization will result in an adverse clinical outcome.

Attached please find the following supporting documentation:

- Clinical notes and pathology reports
- Current laboratory results
- Treatment plan and regimen details
- Relevant imaging reports (CT/PET/MRI)

Please provide a determination within 24 hours. If you require additional information, please contact my office immediately at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Title]