

[Date]
[Insurance Company Name]
[Prior Authorization Department]
[Fax Number / Address]

RE: Prior Authorization Amendment / Escalation of Therapy

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Case/Reference Number: [Original Case Number]

To Whom It May Concern,

I am writing to formally request an amendment to the previously approved prior authorization for [Current Biologic Medication Name]. Due to [Patient Name]'s clinical presentation and inadequate response to the standard dosing regimen, I am requesting an escalation of therapy to:

- **Requested Medication/Dose:** [New Dose, e.g., 90mg]
- **Requested Frequency:** [New Frequency, e.g., every 4 weeks]
- **Requested Start Date:** [Date]

Clinical Justification:

The patient has been on the standard dose of [Medication] since [Date]. Despite adherence, the patient continues to experience [list symptoms, e.g., active flares, elevated inflammatory markers, or radiographic progression]. Clinical assessment via [Tool, e.g., CDAI, PASI, or Mayo Score] indicates a score of [Score], confirming partial response or secondary loss of response.

Standard dosing is no longer sufficient to maintain clinical remission. Dose escalation is medically necessary to prevent irreversible disease progression, hospitalization, or the need for more invasive interventions.

Attached please find supporting documentation, including recent lab results and clinical notes. Please expedite this request to ensure continuity of care.

Sincerely,

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