

[Your Name/Doctor's Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Prior Authorization Amendment - Dosage Change

Patient Name: [Patient First and Last Name]

Patient Date of Birth: [MM/DD/YYYY]

Member ID Number: [ID Number]

Original Authorization Number: [Authorization #]

To Whom It May Concern,

I am writing to request an amendment to the existing prior authorization for the medication [Medication Name]. The patient is currently authorized for [Current Dosage], but I am requesting a change in the dosage to [New Requested Dosage].

The reason for this dosage adjustment is as follows: [Briefly state clinical reason, e.g., inadequate response to current dose, titration schedule, or change in patient weight/labs].

The requested frequency for the new dosage is: [Frequency, e.g., once daily].

This change is medically necessary to ensure the patient achieves the desired therapeutic outcome. All other aspects of the original treatment plan remain the same. Please update the authorization records to reflect this change to prevent any interruption in the patient's treatment.

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[NPI Number]