Date: [Date]

To: [Health Insurance Company Name]
Attn: Utilization Management/Appeals Department
Fax/Address: [Fax Number or Mailing Address]

RE: Prior Authorization Amendment Request

Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Member ID: [Member ID Number]
Original Authorization Reference #: [Reference Number]

Dear Medical Director,

I am writing to formally request an amendment to the existing prior authorization for the above-referenced patient. We are transitioning the patient's treatment plan from the previously approved medication/procedure to an alternative pain management strategy.

Current Authorized Treatment: [Name of Current Medication/Procedure]
Proposed Alternative Treatment: [Name of New Medication/Procedure]
Requested Start Date: [Date]

Clinical Justification for Transition:
The transition to this alternative strategy is medically necessary due to:
[ ] Inadequate pain relief from the current regimen.
[ ] Adverse side effects/intolerance: [List side effects].
[ ] Change in clinical status: [Brief description].
[ ] Step therapy requirements or preferred formulary alignment.

Clinical Summary:
[Provide brief clinical history, including previous treatments tried and failed, and why the new alternative is expected to be more effective for the patient's chronic/acute pain management.]

This amendment is vital to ensure the patient maintains continuity of care and avoids a relapse in pain control or withdrawal symptoms. Please process this amendment to the existing authorization immediately.

If you require additional documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Name]
[Practice Name]
[NPI Number]
[Phone Number]