

**Date:** [Date]

**TO:** [Insurance Company Name]

**ATTN:** Prior Authorization Department / Pharmacy Benefit Manager

**FAX:** [Fax Number]

**PHONE:** [Phone Number]

**RE: Prior Authorization Amendment for Branded Medication**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [DOB]

**Member ID:** [Member ID Number]

**Group Number:** [Group Number]

**Case/Reference Number:** [Original PA Reference Number, if applicable]

Dear Prior Authorization Department,

I am writing to request an amendment to the existing prior authorization for [Patient Name]. While a generic version was previously authorized/considered, I am requesting coverage for the brand-name medication: **[Brand Name Medication]**, [Strength], [Dosage Instructions].

The switch to the branded version is medically necessary due to the following reason(s):

- [Clinical failure or inadequate response to the generic version]
- [Documented adverse reaction or allergy to specific inactive ingredients/fillers in the generic]
- [Requirement for a specific delivery mechanism only available in the branded product]
- [Narrow Therapeutic Index (NTI) concerns requiring brand consistency]

**Clinical Justification:**

[Provide brief clinical summary of why the generic is unsuitable for this specific patient].

Please update the authorization to reflect **Dispense as Written (DAW)** for [Brand Name Medication] to ensure patient safety and therapeutic stability.

Thank you for your prompt attention to this matter. If you require additional documentation, please contact my office at [Office Phone Number].

Sincerely,

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Practice Address]