[Physician Name]
[Practice/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Amendment to Prior Authorization Request

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Original Authorization Number: [Auth Number]
Diagnosis: [ICD-10 Code]

To Whom It May Concern,

I am writing to formally request an amendment to the existing prior authorization for the patient listed above. Due to a change in the patient's clinical status, a modification of the chemotherapy regimen is medically necessary.

Original Approved Regimen: [List original drugs/dosage]

Proposed Modified Regimen: [List new drugs/dosage/frequency]

Reason for Modification:
[Insert clinical reason: e.g., disease progression, intolerance/toxicity to previous agents, or new genomic markers].

The patient is scheduled to begin this modified cycle on [Date]. I have attached updated clinical notes, relevant lab results, and pathology reports to support this change. Please update the authorization record to ensure the claims for these medications are processed correctly.

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

Sincerely,

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