

Date: [Date]

TO: [Insurance Company Name]

ATTN: Prior Authorization/Appeals Department

FAX: [Fax Number]

RE: Prior Authorization Amendment Request

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [Member ID]

Original Authorization #: [Authorization Number]

Dear Medical Reviewer,

This letter is to request an amendment to the existing prior authorization for intravenous (IV) antibiotic therapy for the above-referenced patient. We are requesting a transition from IV administration to oral (PO) antibiotic therapy to complete the remaining course of treatment.

Clinical Justification:

The patient has shown significant clinical improvement, is currently afebrile, and is able to tolerate oral intake. Transitioning to an oral regimen is clinically appropriate, reduces the risk of catheter-associated infections, and allows for a more cost-effective completion of therapy in a less restrictive environment.

Requested Medication Change:

- **Current IV Medication:** [Name of IV Drug, Dosage, and Frequency]
- **New Oral Medication:** [Name of Oral Drug, Dosage, and Frequency]
- **Requested Duration:** [Number of days remaining in treatment]
- **Expected Start Date:** [Date]

Attached are the recent clinical notes and laboratory results supporting this transition. Please update the existing authorization to reflect this change in the route of administration.

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

Sincerely,

[Physician Name]

[NPI Number]

[Practice Name]