Date: [Date]

To: [Insurance Company Name]
Attn: Prior Authorization Department
Fax/Address: [Fax Number or Address]

RE: Prior Authorization Request

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request a prior authorization for the following medication for my patient:

- **Medication Name:** [Drug Name]
- **Dosage and Frequency:** [Dosage and Frequency]
- **Diagnosis:** [Diagnosis Name and ICD-10 Code]

Medical Justification:

The patient has been under my care for [Duration of Treatment] for the condition mentioned above. This medication is medically necessary because:

- [Reason 1: e.g., Patient failed previous treatments: List drugs tried and failed]
- [Reason 2: e.g., Contraindications to formulary alternatives]
- [Reason 3: e.g., Patient is currently stable on this medication]

Included with this letter are relevant medical records and lab results supporting the use of this treatment. Please review this request and provide a decision as soon as possible.

If you have any questions, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO]
[Practice Name]
[NPI Number]
[Tax ID Number]