

[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

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

RE: Prior Authorization Request for Adjusted Hormone Treatment

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]
Case/Reference Number: [If applicable]

To Whom It May Concern,

I am writing to request a prior authorization for an adjustment to the hormone replacement therapy (HRT) for [Patient Name]. The patient has been under my care for [Diagnosis/ICD-10 Code].

The patient is currently prescribed [Current Medication and Dosage]. Based on recent clinical evaluations and laboratory results dated [Date of Bloodwork], it has been determined that the current dosage is insufficient to meet the patient's clinical needs. Specifically, the patient is experiencing [List Symptoms, e.g., breakthrough symptoms, fatigue, mood fluctuations].

The proposed adjusted treatment plan is as follows:

- **Requested Medication:** [Medication Name]
- **Requested Dosage:** [New Dosage/Frequency]
- **Anticipated Duration:** [Duration]

The adjustment is medically necessary to achieve therapeutic hormone levels and mitigate the risks associated with hormone imbalance. Alternative medications have been considered but are not appropriate for this patient because [Reason for specific medication/dose].

Included with this letter are the relevant medical records, including lab results and progress notes, supporting the necessity of this adjustment.

Please contact my office at [Phone Number] if you require further information. We look forward to your prompt response.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]