[Physician Name]
[Clinic/Hospital Name]
[Address]
[Phone Number]
[Fax Number]
[Date]

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

RE: Prior Authorization Request for Brand Name Medication

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

To Whom It May Concern,

I am writing to request a prior authorization for the brand-name medication **[Brand Name Medication]** for my patient, [Patient Name]. This medication is medically necessary for the treatment of [Diagnosis/ICD-10 Code].

The patient has previously attempted treatment with the following formulary/generic alternatives, which were unsuccessful:

- [Generic Drug 1]: [Reason for failure - e.g., lack of efficacy, specific side effect]
- [Generic Drug 2]: [Reason for failure - e.g., allergic reaction, contraindication]

Due to the patient's clinical history and the specific pharmacological profile of [Brand Name Medication], a generic substitution is not appropriate at this time. The patient requires the brand-specific formulation to maintain clinical stability and prevent [Relapse/Hospitalization/Symptom Exacerbation].

Attached please find supporting clinical documentation, including progress notes and medication history. I request that you approve coverage for [Brand Name Medication] for a period of [12 months].

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

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[NPI Number]