URGENT PRIOR AUTHORIZATION REQUEST

DATE: [Date]

TO: [Insurance Company Name]
ATTN: Pharmacy Benefit Manager / Prior Authorization Department
FAX: [Fax Number]

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

Prescribed Medication: [Brand Name Medication]
Dose/Frequency: [Dosage and Frequency]
Diagnosis: [Diagnosis Name and ICD-10 Code]

To Whom It May Concern,

This letter serves as a formal request for an urgent prior authorization for [Brand Name Medication]. This medication is medically necessary for the patient named above to prevent life-threatening cardiovascular events, including [e.g., myocardial infarction, stroke, or heart failure exacerbation].

Clinical Justification:
The patient has been diagnosed with [Condition] and is currently at high risk for clinical instability. The use of generic alternatives or therapeutic equivalents is not appropriate for this patient because:

- [Reason 1: e.g., Failure of previous trials with generic medications X and Y]
- [Reason 2: e.g., Documented adverse reaction or contraindication to generic alternatives]
- [Reason 3: e.g., Requirement for specific pharmacokinetic properties found only in the brand formulation]

Urgency Statement:
A delay in starting or continuing this specific cardiology treatment poses a significant risk to the patient's health and may result in emergency hospitalization or permanent cardiac damage. Please process this request under the "Urgent/Expedited" status.

Please find the attached clinical notes and lab results supporting this request. Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Name]
[NPI Number]

[Practice Name]
[Phone/Fax Number]