Date: [Date]

To: [Insurance Company Name]
Attention: Prior Authorization Department
Fax Number: [Fax Number]
Phone Number: [Phone Number]

RE: Prior Authorization Request for Brand Name Medication

Patient Name: [Patient Name]
Date of Birth: [Patient Date of Birth]
Policy Number: [Insurance ID Number]
Group Number: [Group Number]
Case Reference Number: [If applicable]

Dear Prior Authorization Department,

I am writing to request a prior authorization for **[Brand Name Medication]** for my patient, **[Patient Name]**, for the treatment of pediatric asthma (ICD-10 Code: [Code]).

Clinical Justification:
The patient is currently experiencing [frequent exacerbations/nighttime symptoms/exercise-induced asthma]. Despite current management, the patient's asthma remains uncontrolled. I am prescribing [Brand Name Medication] at a dosage of [Dosage] because [Reason, e.g., patient requires a specific delivery device not available in generic form / patient is a minor and requires this specific formulation for compliance].

Previous Medications and Treatment Failures:
The patient has previously tried and failed the following formulary alternatives:

- [Generic/Alternative Drug Name]: [Dates used] - Reason for failure: [e.g., Lack of efficacy/Adverse reaction]
- [Generic/Alternative Drug Name]: [Dates used] - Reason for failure: [e.g., Inability to use inhaler technique]

Medical Necessity:
In my professional medical opinion, [Brand Name Medication] is medically necessary for this pediatric patient. Use of generic alternatives or other formulary products poses a risk of poor symptom control and potential emergency room visits.

Please review this request for coverage. If you require further clinical documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Name, MD/DO]
[NPI Number]
[Clinic/Practice Name]
[Phone Number]
[Fax Number]