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

RE: Patient Medical Necessity Request
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

Dear Prior Authorization Department,

I am writing to request a formal prior authorization for **[Brand Name Medication]** for the treatment of **[ICD-10 Code / Diagnosis, e.g., Plaque Psoriasis or Atopic Dermatitis]**. The patient has been under my care since [Date].

Clinical Justification:
The patient presents with [Severity: e.g., moderate-to-severe] symptoms involving [Body Surface Area %] of the body. Previous treatments have been insufficient to manage the condition.

Treatment History / Step Therapy Failures:

- **[Failed Medication 1]:** Used for [Duration]. Result: [Failure reason: e.g., inadequate response/adverse reaction].
- **[Failed Medication 2]:** Used for [Duration]. Result: [Failure reason].
- **[Failed Medication 3]:** Used for [Duration]. Result: [Failure reason].

Rationale for Brand Name Medication:
[Brand Name Medication] is medically necessary for this patient because [Reason: e.g., specific mechanism of action, contraindications to generics, or clinical stability on current therapy]. Without this specific medication, the patient is at risk for [List complications/flares].

I have attached the relevant clinical notes, pathology reports, and photographs for your review. Please contact my office at [Phone Number] if you require further information.

Sincerely,

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