URGENT: EXPEDITED PRIOR AUTHORIZATION REQUEST
CLINICAL REASON: ONCOLOGY TREATMENT / TIME-SENSITIVE

Date: [Date]

To: [Insurance Company Name]
Attn: Prior Authorization Department / Oncology Review
Fax Number: [Fax Number]

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

Provider Information
Physician Name: [Physician Name]
NPI Number: [NPI Number]
Phone Number: [Phone Number]
Clinic Contact: [Name of Coordinator/Nurse]

Medication Requested: [Brand Name Medication]
Dosage/Frequency: [Dosage and Frequency]
ICD-10 Code / Diagnosis: [Diagnosis Code and Description]

Dear Medical Director,

I am writing to request an **expedited** prior authorization for [Patient Name] to begin treatment with [Brand Name Medication]. This patient has been diagnosed with [Stage/Type of Cancer].

Based on the patient's clinical presentation, a delay in starting this specific brand-name therapy poses a significant risk to the patient's life and health. [Brand Name Medication] is medically necessary for the following reasons:

- **Clinical Superiority:** [Briefly mention why brand is required over generic, e.g., bioavailability or specific formulation].
- **Previous Therapies:** The patient has previously tried and failed: [List previous medications/treatments].
- **Urgency:** This treatment is required to prevent rapid disease progression and/or severe symptoms.

Attached you will find the relevant clinical notes, pathology reports, and diagnostic test results supporting this request. Given the oncological nature of this diagnosis, we request a determination within 24-48 hours.

Please contact my office at [Phone Number] if any additional documentation is required.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name]