PRIOR AUTHORIZATION REQUEST: BRAND NAME PAIN MEDICATION

Date: [Date]

TO: [Insurance Company Name]
ATTN: Pharmacy Review Department
FAX: [Insurance Fax Number]

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

Prescriber Information:
Name: [Physician Name]
NPI Number: [NPI Number]
Phone: [Phone Number]
Fax: [Fax Number]

Requested Medication: [Brand Name Medication]
Strength: [Strength, e.g., 10mg]
Dosage: [Frequency, e.g., Twice Daily]
Duration: [Expected Length of Treatment]

Diagnosis: [Diagnosis Name and ICD-10 Code]

Medical Justification:

The patient has been diagnosed with [Diagnosis] and requires the brand-name medication [Medication Name] for the following reasons:

1. Previous Medications Failed:
The patient has tried and failed the following formulary/generic alternatives:

- [Generic Name 1]: Failed due to [Reason, e.g., lack of efficacy/side effects]
- [Generic Name 2]: Failed due to [Reason]

2. Clinical Necessity:
[Explain why the brand name is required, e.g., allergy to generic fillers, specific delivery mechanism of the brand, or clinical instability on generic versions.]

3. Supporting Documentation:
Attached please find [Medical Records / Lab Results / Pain Scale History] documenting the patient's condition and necessity for this specific treatment.

I request that you approve coverage for [Brand Name Medication] to ensure the patient's pain is managed effectively and to prevent further clinical decline.

Sincerely,

[Physician Signature]
[Physician Printed Name]