Date: [Date]

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

RE: Urgent Prior Authorization Request for Brand Name Medication

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

Dear Medical Reviewer,

I am writing to request a prior authorization for **[Brand Name Medication]** for the treatment of **[ICD-10 Code/Diagnosis, e.g., Rheumatoid Arthritis]**. This patient has been under my care since [Date].

Clinical Justification:
The patient presents with [list symptoms/disease activity scores]. Based on the patient's medical history and current clinical status, [Brand Name Medication] is medically necessary for the following reasons:

- **Trial and Failure of Preferred Agents:** The patient has previously tried and failed the following medications: [List Drug A, Drug B, etc.] for a period of [Number] months with inadequate response or intolerable side effects.
- **Contraindications:** The patient has contraindications to the formulary alternatives [List Alternatives] due to [Reason, e.g., hepatic impairment, drug interaction].
- **Disease Severity:** The patient's condition is [moderate/severe] and requires the specific mechanism of action provided by [Brand Name Medication] to prevent irreversible joint damage or systemic complications.

Treatment Plan:
The requested dosage is [Dosage] to be administered [Frequency].

Attached please find supporting clinical documentation, including office notes, lab results, and imaging reports.

Please contact my office at [Phone Number] if you require further information. I look forward to your timely approval of this request.

Sincerely,

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

[Practice Name]
[Address]
[Phone Number]