Date: [Date]

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

RE: Urgent Request for Prior Authorization

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case ID (if applicable): [Case ID]

Prescriber Name: [Physician Name]
NPI Number: [NPI Number]
Clinic Name: [Practice Name]
Clinic Contact: [Phone/Fax]

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

Dear Medical Reviewer,

I am writing to request a prior authorization for the brand-name medication listed above. This patient has been diagnosed with [Diagnosis] and requires treatment with [Brand Name Medication] to manage their condition and prevent further disease progression.

Clinical Justification:
The patient has previously attempted and failed the following formulary alternatives/generic medications:

- [Failed Medication #1]: [Dates used/Duration]. Reason for failure: [e.g., Inadequate response/Side effects].
- [Failed Medication #2]: [Dates used/Duration]. Reason for failure: [e.g., Allergic reaction/Contraindication].

Medical Necessity:
The use of the brand-name medication is medically necessary because: [Briefly describe clinical severity, e.g., active flares, risk of surgery, or specialized delivery system needed]. Switching to

a generic or alternative agent at this time poses a significant risk to the patient's stability and health outcomes.

Please find attached supporting documentation, including clinic notes, recent lab results, and diagnostic reports (Endoscopy/Imaging).

Thank you for your prompt attention to this request. Please contact my office if further information is required.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]