Date: [Date]

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

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

Subject: Request for Prior Authorization for Brand Name Medication: [Brand Name Drug]

Dear Prior Authorization Department,

I am writing to request a formal prior authorization for **[Brand Name Medication]** for my patient, [Patient Name]. This patient has been diagnosed with [Specific Condition/Organ Transplant Type] and requires this specific brand-name immunosuppressant to ensure therapeutic stability and prevent graft rejection or disease flare.

Clinical Justification:

- **Diagnosis:** [Diagnosis Code/ICD-10]
- **Medical Necessity:** [Briefly explain why the brand name is required, e.g., narrow therapeutic index, history of adverse reactions to generic fillers, or previous failure on generic equivalents].
- **Previous Medications Tried:** [List Generic Names] from [Start Date] to [End Date].
- **Outcome of Previous Trials:** [e.g., Sub-therapeutic blood levels, allergic reaction, or worsening symptoms].

Given the critical nature of immunosuppression for this patient's health, a switch to a generic alternative poses a significant clinical risk due to potential variations in bioavailability and absorption rates. For these reasons, I am requesting that you approve the brand-name version of this medication as medically necessary.

Included with this letter are [supporting documents, e.g., lab results, clinical notes]. Please contact my office at [Phone Number] if you require further information.

Sincerely,

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