[Date]

[Insurance Company Name]
[Prior Authorization Department Address]
[City, State, Zip Code]
Fax: [Insurance Fax Number]

RE: Prior Authorization Request for Brand Name Medication

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

To Whom It May Concern,

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

Medical Necessity and Clinical Justification:
The patient requires the brand-name formulation because:

- [Reason 1: e.g., Failure of generic alternatives (list specific drugs and dates)]
- [Reason 2: e.g., History of adverse reactions to generic excipients/fillers]
- [Reason 3: e.g., Requirement for specific delivery device/dosage not available in generic]
- [Reason 4: e.g., Clinical instability on previous therapeutic alternatives]

Current Clinical Status:
[Briefly describe laboratory results, such as A1C levels, TSH levels, or growth hormone markers, that justify the need for this specific medication].

Due to the patient's medical history and the specific requirements of their endocrine disorder, I believe [Brand Name Medication] is medically necessary for the patient's health and stability.

Please contact my office at [Phone Number] if you require additional documentation or clinical notes.

Sincerely,

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