Date: [Date]

Recipient: [Health Insurance Plan Name]
Attention: [Prior Authorization/Appeals Department]
Fax Number: [Fax Number]

RE: Dosage Adjustment Authorization Request

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

Dear Medical Director,

I am writing to request a dosage adjustment authorization for **[Medication Name]** for the treatment of **[Diagnosis/Condition]** (ICD-10 code: [Code]).

The patient is currently prescribed **[Current Dosage]**, but I am requesting an adjustment to **[Requested Dosage]**. This request is based on the patient's clinical response and the failure of required step therapy protocols.

Step Therapy History:

- **Step 1 Medication:** [Medication Name]
  Dates used: [Start Date] to [End Date]
  Outcome: [Inadequate response / Adverse reaction]
- **Step 2 Medication:** [Medication Name]
  Dates used: [Start Date] to [End Date]
  Outcome: [Inadequate response / Adverse reaction]

Clinical Justification for Dosage Adjustment:

[Insert brief clinical explanation, e.g., "The patient continues to experience breakthrough symptoms at the standard dose," or "Recent lab results indicate the current dose is sub-therapeutic."]

Based on the patient's medical history and the failure of the preferred step therapy medications, the requested dosage of [Medication Name] is medically necessary for the stabilization of the patient's condition.

Thank you for your prompt review of this request. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Clinic/Hospital Name]