Date: [Date]

To: [Insurance Company Name]
Attention: Prior Authorization Department
Fax/Address: [Fax Number or Mailing Address]

RE: Prior Authorization Request for Medication Refill

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

Dear Prior Authorization Department,

I am writing to request a prior authorization for a medication refill for my patient, [Patient Name].

Medication Information:

- **Requested Medication:** [Medication Name and Strength]
- **Dosage/Frequency:** [Dosage Instructions]
- **Diagnosis:** [Diagnosis Name and ICD-10 Code]
- **Expected Duration:** [Length of Treatment]

Clinical Justification:
The patient has been stable on this medication since [Start Date]. This medication is medically necessary for the management of the patient's condition because [briefly state reason, e.g., previous failure of formulary alternatives, specific contraindications, or maintenance of current clinical stability].

Failure to refill this medication may result in [list potential risks, e.g., recurrence of symptoms, hospitalization, or adverse health outcomes].

Please review this request for continued coverage. If you require additional clinical documentation, please contact my office at [Phone Number].

Sincerely,

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