

[Physician Name]  
[Clinic/Hospital Name]  
[Address]  
[City, State, Zip Code]  
[Phone Number]  
[Email]

[Date]

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

**RE: Prior Authorization Request for Off-Label Treatment**

**Patient Name:** [Patient Full Name]  
**Date of Birth:** [DOB]  
**Member ID:** [ID Number]  
**Group Number:** [Group Number]  
**Case Reference Number:** [Reference Number, if applicable]

To Whom It May Concern,

I am writing to request a prior authorization for the off-label use of [**Medication/Procedure Name**] for my patient, [**Patient Name**], to treat [**Diagnosis/Condition**] (ICD-10 code: [Code]).

**Clinical Background:**

The patient has been under my care since [Date]. They present with [Symptoms/Severity]. To date, the patient has tried and failed the following FDA-approved therapies:

- [Treatment A]: [Duration] - Result: [Reason for failure/Side effects]
- [Treatment B]: [Duration] - Result: [Reason for failure/Side effects]

**Medical Necessity for Off-Label Use:**

Although [**Medication/Procedure Name**] is not currently FDA-approved specifically for [**Diagnosis**], its use is medically necessary and supported by clinical evidence for this patient. I have attached peer-reviewed studies and clinical guidelines demonstrating the efficacy of this treatment for this specific condition.

**Treatment Plan:**

The proposed treatment plan includes [Dosage/Frequency/Duration]. We expect this intervention to [Expected Outcome, e.g., prevent hospitalization, improve mobility].

I request that you approve this request to ensure the patient receives the necessary standard of care. If you require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical License Number]

**Enclosures:**

- Patient Clinical Notes
- Peer-reviewed Journal Articles/Supporting Data
- Letter of Medical Necessity