Date: [Date]

To: [Insurance Company Name]
Attention: Medical Review Department
Fax: [Insurance Fax Number]

RE: Authorization Request for Off-Label Use
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Policy ID Number]
Group Number: [Group Number]

Dear Medical Reviewer,

I am writing to request authorization for the use of **[Medication/Treatment Name]** for my patient, **[Patient Name]**, who is currently under my care for **[Diagnosis/ICD-10 Code]**.

While **[Medication Name]** is FDA-approved for **[FDA Approved Indication]**, it is being prescribed here for off-label use. This clinical decision is based on the patient's medical history and the following reasons:

- **Failed Previous Therapies:** The patient has previously tried and failed the following standard treatments: [List Previous Medications/Treatments].
- **Clinical Justification:** [Briefly describe why this medication is necessary for this specific patient].
- **Supporting Evidence:** Peer-reviewed literature and clinical guidelines support the efficacy of this treatment for [Diagnosis]. [Optional: Mention specific study or journal].

Based on the patient's condition and the lack of success with conventional therapies, I believe **[Medication Name]** is medically necessary to prevent further progression of the disease and improve the patient's quality of life.

I have attached relevant clinical notes and supporting documentation for your review. Please contact my office at [Phone Number] if you require further information.

Sincerely,

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