

Date: [Date]

To: [Insurance Company Name]

Attn: [Department Name/Prior Authorization Department]

Fax/Address: [Fax Number or Address]

RE: Request for Off-Label Drug Approval

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy Number: [Policy Number]

Group Number: [Group Number]

Dear Medical Director,

I am writing to request coverage for **[Drug Name]** for my patient, **[Patient Name]**, who is currently under my care for the treatment of **[Chronic Disease Name]** (ICD-10 Code: [Code]).

While **[Drug Name]** is not currently FDA-approved specifically for **[Disease Name]**, its use is medically necessary for this patient due to the following clinical reasons:

- **Patient History:** [Briefly describe the severity and duration of the chronic condition].
- **Previous Treatments:** The patient has failed standard FDA-approved therapies, including [List previous medications/treatments tried and why they failed or were discontinued].
- **Clinical Justification:** Current peer-reviewed medical literature and clinical guidelines support the use of [Drug Name] for this condition because [Briefly state efficacy/safety data].

The use of this medication is critical to preventing [List potential complications, hospitalizations, or disease progression] and improving the patient's quality of life.

Attached please find supporting documentation, including [Medical Records / Peer-Reviewed Journal Articles / Clinical Guidelines].

I request that you approve this off-label use for **[Patient Name]**. If you have any questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]