[Date]

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

RE: Prior Authorization Request for Biological Therapy

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

Dear Medical Director,

I am writing to request a prior authorization for **[Name of Biological Medication]** for the treatment of **[Diagnosis/ICD-10 Code]**. My patient has been under my care since [Date].

Clinical Justification:
The patient presents with [Moderate/Severe] symptoms including [list symptoms, e.g., joint swelling, morning stiffness, high ESR/CRP levels]. The use of this biological agent is medically necessary to prevent irreversible joint damage and maintain functional status.

Previous Therapies:
The patient has previously tried and failed the following treatments:

- [Drug Name 1]: [Dates used] - Reason for discontinuation: [Failure/Side Effects]
- [Drug Name 2]: [Dates used] - Reason for discontinuation: [Failure/Side Effects]
- [Drug Name 3]: [Dates used] - Reason for discontinuation: [Failure/Side Effects]

Proposed Treatment Plan:
Dosage: [Dose, e.g., 50mg]
Frequency: [Frequency, e.g., every 2 weeks]
Route of Administration: [Subcutaneous/Intravenous]

Attached are relevant clinical notes, lab results, and imaging reports supporting this request. Please contact my office at [Phone Number] if further information is required.

Sincerely,

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