Date: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX: [Insurance Fax Number]

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

Subject: Urgent Request for Prior Authorization: [Name of Biologic Medication]

Dear Medical Reviewer,

I am writing to request prior authorization for **[Name of Biologic Medication]** for the treatment of **[ICD-10 Code] [Diagnosis, e.g., Crohn's Disease / Ulcerative Colitis]** for my patient, [Patient Name].

Clinical Summary:
The patient was diagnosed with [Diagnosis] on [Date of Diagnosis]. Their current disease state is classified as [Moderate/Severe]. Symptoms include [List symptoms, e.g., chronic diarrhea, rectal bleeding, abdominal pain, weight loss]. Recent diagnostic tests including [Colonoscopy/CT/MRI] performed on [Date] showed [Summary of findings].

Treatment History and Failures:
The patient has previously attempted and failed the following therapies:

- [Previous Medication 1]: [Dates used] - Reason for failure: [e.g., Lack of efficacy/Side effects]
- [Previous Medication 2]: [Dates used] - Reason for failure: [e.g., Lack of efficacy/Side effects]
- [Previous Medication 3]: [Dates used] - Reason for failure: [e.g., Lack of efficacy/Side effects]

Proposed Treatment Plan:
I am prescribing [Name of Biologic Medication] at a dosage of [Dosage and Frequency]. Based on the patient's clinical history and the severity of their condition, this biological therapeutic is medically necessary to induce and maintain clinical remission and prevent irreversible bowel damage or surgery.

Please find the attached supporting documentation, including recent clinic notes, pathology reports, and lab results.

Thank you for your prompt attention to this request. If you have any questions, please contact my office at [Phone Number].

Sincerely,

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