Date: [Date]

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

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

Dear Medical Reviewer,

I am writing to request prior authorization for **[Medication Name]** for the treatment of **[ICD-10 Code/Diagnosis, e.g., Moderate to Severe Plaque Psoriasis]**. This patient has been under my care since [Date].

Clinical Justification:
The patient presents with [Percentage]% Body Surface Area (BSA) involvement affecting [Specific Areas, e.g., face, hands, genitals]. The patient's current DLQI (Dermatology Life Quality Index) score is [Score].

History of Failed Therapies:

- [Topical Steroid Name]: Used for [Duration]. Outcome: [Inadequate response/Side effects].
- [Phototherapy/PUVA]: Used for [Duration]. Outcome: [Inadequate response/Inaccessible].
- [Methotrexate/Cyclosporine/Acitretin]: Used for [Duration]. Outcome: [Failure/Contraindication].

Prescription Plan:
Loading Dose: [Dose/Frequency]
Maintenance Dose: [Dose/Frequency]

Based on the severity of the disease and the failure of previous systemic treatments, [Medication Name] is medically necessary to prevent further disease progression and improve the patient's quality of life. Please contact my office at [Phone Number] if further information is required.

Sincerely,

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