[Date]

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

RE: Prior Authorization Request for Biological Therapeutic

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Case Reference Number: [If applicable]

Dear Medical Reviewer,

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

Clinical Justification:
The patient has a confirmed diagnosis of [Diagnosis] based on [Clinical Findings/Tests]. The patient's current symptoms include [List Symptoms], which significantly impact their activities of daily living and neurological function.

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

- [Drug Name 1]: Used for [Duration]. Reason for discontinuation: [Failure/Side Effects].
- [Drug Name 2]: Used for [Duration]. Reason for discontinuation: [Failure/Side Effects].

Rationale for Treatment:
Based on the patient's medical history and the severity of the disease, I have determined that **[Name of Biological Medication]** is medically necessary. Clinical data supports the use of this biological agent to reduce [Relapse Rates/Disease Progression/Symptom Severity] in patients with this specific profile.

Requested Dosage and Administration:
Dosage: [Amount/Dose]
Frequency: [Frequency of Administration]
Route: [Subcutaneous/Intravenous/Other]
Duration: [Requested Length of Authorization]

Enclosed are the patient's relevant medical records, lab results, and imaging reports. Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]
[Phone Number]