DATE: [Date]

TO: [Insurance Company Name]
ATTN: Prior Authorization Department
FAX/PORTAL: [Fax Number or Portal Link]

RE: Prior Authorization Request for Oncology Biological Therapy

PATIENT INFORMATION:
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

PRESCRIBER INFORMATION:
Physician Name: [Physician Name]
NPI Number: [NPI Number]
Practice Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]

DIAGNOSIS & CLINICAL INFORMATION:
Primary Diagnosis: [Diagnosis Name] (ICD-10: [Code])
Cancer Stage: [Stage, e.g., IV Metastatic]
Requested Medication: [Drug Name (Brand/Generic)]
Dosage/Frequency: [Dose and Schedule]
HCPCS Code: [J-Code, if applicable]

MEDICAL NECESSITY JUSTIFICATION:

This letter serves as a formal request for the coverage of **[Drug Name]** for the treatment of **[Patient Name]**. The patient has been diagnosed with **[Diagnosis]** based on **[Biopsy/Imaging/Pathology Date]**.

Relevant Biomarkers/Genetic Testing:
The patient has tested positive/negative for [Biomarker, e.g., HER2, PD-L1, EGFR, KRAS]. Results are attached.

Previous Therapies Attempted:
1. [Drug Name] - Dates: [Start/End] - Outcome: [Reason for Failure/Progression]
2. [Drug Name] - Dates: [Start/End] - Outcome: [Reason for Failure/Intolerance]

Clinical Rationale:
Based on [NCCN Guidelines/Peer-reviewed Literature], **[Drug Name]** is the standard of care for this patient's specific diagnosis and clinical presentation. Delaying this biological therapy may result in [Disease Progression/Severe Morbidity].

ATTACHMENTS INCLUDED:
- Clinical Progress Notes
- Pathology and Lab Reports
- Relevant Imaging Results
- FDA Label/NCCN Guidelines supporting use

Please contact our office at [Phone Number] if further information is required for an expedited review.

Sincerely,

[Physician Signature]
[Physician Printed Name]