[Date]
[Insurance Company Name]
[Prior Authorization Department]
[Fax Number/Address]

RE: Prior Authorization Request for Biological Therapy
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]
Case Reference Number: [If applicable]

To Whom It May Concern,

I am writing to request prior authorization for the use of **[Name of Biologic Medication]** for my pediatric patient, [Patient Name]. This patient has been diagnosed with [Diagnosis/ICD-10 Code] and is currently under my care at [Clinic Name].

Clinical Justification:
The patient presents with [Severe/Moderate] symptoms, including [List key symptoms]. Due to the patient's age and the progression of the disease, biological therapy is medically necessary to prevent long-term complications and improve quality of life.

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

- [Therapy 1]: [Dates used] - Reason for failure: [e.g., Inefficacy/Side effects]
- [Therapy 2]: [Dates used] - Reason for failure: [e.g., Contraindicated for pediatric use]

Proposed Treatment Plan:
- Medication: [Medication Name]
- Dosage: [Dosage based on weight/age]
- Frequency: [Frequency of administration]
- Route: [Subcutaneous/IV Infusion]
- Duration: [Expected length of treatment]

Attached please find the patient's clinical notes, lab results, and relevant diagnostic imaging for your review. Please contact our office at [Phone Number] if further information is required.

Sincerely,

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