URGENT REQUEST: EXPEDITED REVIEW REQUIRED

Date: [Date]
To: [Insurance Company Name]
Department: Prior Authorization Department
Fax Number: [Fax Number]

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

Dear Medical Reviewer,

I am writing to request an **expedited prior authorization** for **[Name of Biological Therapeutic]** for the treatment of **[Patient Diagnosis/ICD-10 Code]**. My patient's condition is severe and requires immediate intervention to prevent clinical deterioration or irreversible damage.

Clinical Justification:
The patient presents with [Briefly describe severity of symptoms/disease activity]. Due to the aggressive nature of this condition, any delay in starting biological therapy poses a significant risk to the patient's health, including [List specific risks: e.g., organ damage, hospitalization, loss of function].

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

- [Therapy 1]: [Reason for failure/Duration]
- [Therapy 2]: [Reason for failure/Duration]

Treatment Plan:
Requested Medication: [Medication Name]
Dosage: [Dosage]
Frequency: [Frequency]
Duration: [Duration of Treatment]

Based on the clinical evidence and the patient's medical history, this biological therapeutic is medically necessary. I request a determination within [24/48/72] hours due to the urgent nature of this request.

Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Physician Name]
[Practice Name]
[NPI Number]
[Tax ID Number]