[Date]

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

RE: Continuation of Care Prior Authorization Request
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group Number]
Request Type: Urgent / Standard

To Whom It May Concern,

I am writing to request a prior authorization for the continued use of **[Name of Biological Medication]** for my patient, **[Patient Name]**, for the treatment of **[Diagnosis/ICD-10 Code]**.

The patient has been receiving this biological therapy since **[Start Date]**. During this time, the patient has shown significant clinical improvement and stabilization of their condition. Specifically, the patient has experienced:

- [Clinical Improvement 1: e.g., Reduced inflammation markers]
- [Clinical Improvement 2: e.g., Decrease in frequency of flares]
- [Clinical Improvement 3: e.g., Improved functional status/quality of life]

This therapy is medically necessary to maintain the patient's current health status. Discontinuation or switching of this biological agent poses a high risk of treatment failure, development of anti-drug antibodies, and a severe relapse of the underlying disease.

The patient previously failed the following therapies before starting this medication:

- [Failed Medication 1] - [Reason for failure/Duration]
- [Failed Medication 2] - [Reason for failure/Duration]

Included with this letter are recent clinical notes, lab results, and documentation of the patient's positive response to the current treatment plan.

Please expedite the review of this request to ensure there is no gap in the patient's treatment schedule. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[NPI Number]
[Practice Name]
[Phone Number]
[Fax Number]