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

RE: Prior Authorization Request for Dose Escalation
Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Member ID: [Member ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number, if applicable]

Dear Medical Director,

I am writing to request a prior authorization for a dose escalation of [Name of Biologic Medication] for the treatment of [Diagnosis/ICD-10 Code]. The patient has been on the standard induction/maintenance dose of [Current Dose and Frequency] since [Start Date].

Despite adherence to the standard dosing regimen, the patient has experienced a suboptimal clinical response characterized by [List specific symptoms, e.g., increased inflammation, return of symptoms, or rising biomarkers]. Clinical assessments performed on [Date] show [List Lab Results, e.g., low trough levels or presence of anti-drug antibodies].

Based on the patient's current disease activity and clinical guidelines, I am requesting an increase in dosage to [Requested Dose] administered every [Requested Frequency]. This escalation is medically necessary to achieve clinical remission and prevent further disease progression or permanent damage.

Enclosed are relevant clinical notes, laboratory results, and imaging reports supporting this request. Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Practice Name]