[Physician Name]
[Clinic/Hospital Name]
[Address]
[Phone Number]
[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]

RE: Prior Authorization Request for Off-Label Use

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

To Whom It May Concern,

I am writing to request a prior authorization for the use of **[Drug Name]** for my patient, **[Patient Name]**. While this biological therapeutic is currently FDA-approved for [List Approved Indications], I am prescribing it for the off-label treatment of **[Patient's Diagnosis/ICD-10 Code]**.

Clinical Justification:
The patient presents with [Briefly describe severity of symptoms]. Standard therapies have been exhausted or are contraindicated. Specifically, the patient has tried and failed the following treatments:

- [Previous Medication 1]: [Result/Reason for Failure]
- [Previous Medication 2]: [Result/Reason for Failure]

Supporting Evidence:
The use of [Drug Name] for [Diagnosis] is supported by the following clinical evidence and peer-reviewed literature:

- [Citation 1: Study Title/Journal]
- [Citation 2: Clinical Guideline/Compendia]

Based on the patient's clinical history and the supporting data, I believe [Drug Name] is medically necessary to prevent further disease progression and improve the patient's quality of life.

Please find attached the patient's medical records and relevant clinical studies. If you have any questions, please contact my office at [Phone Number].

Sincerely,

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