[Date]

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

RE: Prior Authorization Request for Biological Therapeutic Infusion

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case ID: [If applicable]

To Whom It May Concern,

I am writing to request prior authorization for **[Name of Biological Medication]** for the treatment of **[Patient's Diagnosis]** (ICD-10 Code: **[Code]**). The patient is scheduled to receive these infusions at **[Infusion Center Name]**.

Clinical Justification:
The patient has a confirmed diagnosis of [Diagnosis] as evidenced by [Diagnostic Tests/Labs]. Their current symptoms include [List Symptoms]. This medication is medically necessary because [Reason why this specific biologic is required].

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

- [Previous Medication 1]: [Dates used], [Reason for discontinuation/failure]
- [Previous Medication 2]: [Dates used], [Reason for discontinuation/failure]

Treatment Plan:
- **Medication:** [Medication Name]
- **HCPCS Code:** [J-Code]
- **Dosage:** [e.g., 5mg/kg]
- **Frequency:** [e.g., Every 8 weeks]
- **Duration:** [e.g., 12 months]

Attached please find the patient's clinical notes, relevant lab results, and diagnostic reports supporting this request. Please contact our office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Practice Name]
[Contact Email/Phone]