Date: [Date]
To: [Insurance Company Name]
Attention: Prior Authorization Department
Fax/Phone: [Insurance Contact Info]

RE: Patient Weight-Based Dosage Authorization
Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request a prior authorization for [Medication Name] for my patient, [Patient Name], who is currently under my care for the treatment of [Diagnosis/ICD-10 Code].

The requested dosage of [Dosage Amount] is based on the patient's current weight of [Weight in kg/lbs], recorded on [Date]. According to pediatric clinical guidelines, the standard dosing for this medication is [X] mg/kg. As the patient is a growing child, weight-based adjustments are medically necessary to ensure therapeutic efficacy and safety.

Requested Medication Details:
- Medication: [Medication Name]
- Dose: [Specific Dose]
- Frequency: [Frequency]
- Duration: [Expected Duration]

Failure to provide this specific weight-based dose may result in sub-therapeutic levels, treatment failure, or increased risk of adverse events. [Optional: Mention previous medications failed or why alternatives are inappropriate for this weight/age].

Please expedite this request to avoid a gap in the patient's treatment. If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]
[Phone Number]