Date: [Insert Date]

To: [Insurance Company Name/Pharmacy Benefit Manager]
Attention: Prior Authorization Department
Fax/Address: [Insert Fax Number or Address]

RE: Authorization for High-Dose Insulin Therapy

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Insert Policy Number]
Group Number: [Insert Group Number]

To Whom It May Concern,

I am writing to request a formal authorization and medical necessity coverage for high-dose insulin therapy for the above-mentioned patient. This request is for [Name of Insulin Product] at a dosage of [Insert Units] per day, which exceeds the standard quantity limits.

Clinical Justification:
The patient has been diagnosed with [Diagnosis/ICD-10 Code, e.g., Type 2 Diabetes with severe insulin resistance]. Despite adherence to standard dosing regimens and the use of adjunct therapies such as [List Previous Medications, e.g., Metformin, GLP-1 agonists], the patient's HbA1c remains elevated at [Insert Percentage]%.

Due to [Specific Reason, e.g., extreme insulin resistance, pregnancy, or post-surgical requirements], the patient requires high-concentration insulin (e.g., U-500) or a high-volume delivery protocol to achieve glycemic control and prevent acute complications such as DKA or long-term vascular damage.

Requested Medication Details:

- **Medication:** [Insulin Name and Concentration]
- **Daily Dose:** [Total Units per 24 hours]
- **Quantity Requested:** [Number of vials/pens per month]

Please expedite this request to ensure the patient maintains continuity of care. Should you require further documentation or clinical notes, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]
Physician Name: [Print Name]
NPI Number: [Insert NPI Number]
Practice Name: [Insert Practice Name]