[Physician Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

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

RE: Urgent Prior Authorization Request for High-Dose Therapy

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Group Number: [Group Number]
Case/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request prior authorization for high-dose [Medication/Treatment Name] for my patient, [Patient Name]. This patient has been diagnosed with [Specific Diagnosis] (ICD-10 Code: [Code]).

The patient has previously attempted standard dosing of [Medication Name] for a period of [Duration], which resulted in [Inadequate Response/Partial Remission]. Due to the severity of the patient's condition and the failure of standard protocols, high-dose therapy is medically necessary to [Goal of Treatment, e.g., achieve clinical stability/prevent disease progression].

Clinical Justification:
[Briefly list clinical evidence, lab results, or failed previous therapies here.]

Proposed Treatment Plan:
- Medication/Procedure: [Name]
- Dosage: [High-Dose Amount]
- Frequency: [Frequency]
- Duration: [Expected Length of Treatment]

Please review this request urgently to avoid any disruption in the patient's care. If you require additional documentation, please contact my office at [Phone Number].

Sincerely,

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