

Date: [Insert Date]

To: [Insurance Provider Name]

Attn: Medical Review/Prior Authorization Department

Fax/Address: [Insert Fax Number or Address]

RE: Authorization Request for High-Dose Corticosteroid Therapy

Patient Name: [Insert Patient Name]

Date of Birth: [Insert DOB]

Policy Number: [Insert Policy Number]

Group Number: [Insert Group Number]

Case Reference Number: [Insert Reference Number, if applicable]

Dear Medical Review Officer,

I am writing to request authorization for high-dose corticosteroid therapy for the above-mentioned patient. This treatment is medically necessary based on the patient's clinical diagnosis and current health status.

Clinical Diagnosis: [Insert Diagnosis, e.g., Acute Multiple Sclerosis Exacerbation, Severe Vasculitis, etc.]

ICD-10 Code: [Insert Code]

Proposed Treatment Plan:

- **Medication:** [Insert Drug Name, e.g., Methylprednisolone]
- **Dosage:** [Insert Dosage, e.g., 1000mg daily]
- **Route of Administration:** [Insert Route, e.g., Intravenous or Oral]
- **Duration:** [Insert Number of Days]
- **Setting:** [Insert Setting, e.g., Inpatient, Outpatient Clinic, or Home Infusion]

Medical Justification:

The patient is experiencing [describe symptoms/severity]. High-dose corticosteroid therapy is the standard of care for this condition to reduce inflammation and prevent further neurological or systemic damage. [Optional: Mention previous failed treatments or why lower doses are insufficient].

Please expedite this request as the patient requires immediate intervention to stabilize their condition. Should you require additional documentation or clinical notes, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Insert Name]

NPI Number: [Insert NPI]

Facility Name: [Insert Facility Name]