[Physician Name]
[Clinic/Institution Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

RE: Authorization for High-Dose Hormone Replacement Therapy

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Insurance ID: [Insurance ID Number]

To Whom It May Concern,

I am writing to provide formal authorization and medical necessity documentation for high-dose Hormone Replacement Therapy (HRT) for my patient, [Patient Name].

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. Based on clinical evaluation, laboratory results, and the patient's history, standard dosing regimens have proven insufficient to achieve therapeutic hormone levels or symptom relief. Specifically, [mention reason: e.g., malabsorption, high metabolic clearance, or persistent physiological symptoms].

Prescribed Regimen:
Medication: [Medication Name]
Dosage: [Specific High Dose, e.g., 8mg daily]
Frequency: [Frequency]
Route: [Route of Administration]

I have discussed the potential risks and benefits of supra-therapeutic dosing with the patient, including [mention risks, e.g., cardiovascular or thromboembolic risks]. The patient has provided informed consent, and we will continue frequent monitoring of serum levels and clinical markers to ensure safety.

Please authorize this prescription as medically necessary for the effective treatment of the patient's condition.

Sincerely,

[Physician Signature]

[Physician Name, Title]
[NPI Number]