Date: [Insert Date]

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

RE: Authorization for High-Dose Medication

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Member ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request an authorization for a dosage that exceeds the standard FDA-recommended limits for the following medication:

Medication Name: [Insert Medication Name]
Requested Dosage: [Insert Total Daily Dosage]
Diagnosis: [Insert Diagnosis and ICD-10 Code]

Clinical Justification:

The patient has been under my care since [Date]. Despite trials at standard dosing, the patient continues to experience significant symptoms including [List Symptoms]. Previous treatments and standard doses of [List Previous Medications Tried] have proven ineffective or resulted in partial response only.

The patient has demonstrated improved clinical stability at the requested higher dosage without significant adverse effects. Based on the patient's clinical presentation, metabolic profile, and severity of illness, this high-dose regimen is medically necessary to prevent relapse, hospitalization, or [List Other Risks].

I will continue to monitor the patient closely for side effects, including regular [List Monitoring, e.g., EKGs, blood levels, or metabolic panels].

Please expedite this request to ensure continuity of care. If you require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/NP]
NPI Number: [Insert NPI]

Practice Name: [Practice Name]
Phone: [Phone Number]