

**Date:** [Date]

**To:** [Insurance Company Name / Authorization Department]

**Attention:** [Contact Person or Department]

**Fax/Email:** [Fax Number or Email Address]

**RE: Request for Outpatient High-Dose Intravenous (IV) Therapy Authorization**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Member ID:** [Insurance Member ID]

**Policy/Group Number:** [Group Number]

To Whom It May Concern,

I am writing to formally request prior authorization for high-dose intravenous therapy for the above-mentioned patient. This treatment is medically necessary for the management of [Diagnosis/Condition Name], ICD-10 code: [ICD-10 Code].

**Treatment Plan Details:**

- **Medication/Solution:** [Name of Medication/Substance]
- **Dosage:** [Specific High-Dose Amount, e.g., 50g]
- **Frequency:** [e.g., 3 times per week]
- **Duration:** [e.g., 6 months]
- **Location:** [Name of Outpatient Clinic/Facility]

**Clinical Justification:**

The patient has been diagnosed with [Condition] and has previously attempted [list previous failed treatments or medications]. Due to [reason for high-dose IV necessity, e.g., malabsorption, severity of symptoms, or lack of response to oral therapy], high-dose intravenous administration is required to achieve therapeutic levels and prevent [potential complications].

Attached please find the patient's recent clinical notes, lab results, and medical history supporting this request.

Please provide a response via fax or mail within [number of days] business days. Should you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[NPI Number]

[Practice Name]

[Practice Address]