

Date: [Date]

To: [Insurance Company Name]

Attention: Prior Authorization Department

Fax Number: [Fax Number]

Phone Number: [Phone Number]

RE: Patient Coverage Request for Brand Name Medication

Patient Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [Member ID Number]

Group Number: [Group Number]

Case Reference Number: [Reference Number, if applicable]

Dear Prior Authorization Department,

I am writing to request a medical necessity override for the "Dispense as Written" (DAW) requirement for my patient, [Patient Name]. I am requesting coverage for the brand-name medication [**Brand Name Drug**] at the dose of [**Dosage**].

Clinical Justification:

The patient requires the brand-name formulation rather than the generic equivalent due to the following reason(s):

- [] **Therapeutic Failure:** The patient has previously trialed the generic version(s) [Name of Generic] from [Date] to [Date] and experienced inadequate symptom control or a return of symptoms.
- [] **Adverse Reaction:** The patient experienced the following documented allergic reaction or intolerable side effect(s) specifically attributed to the generic formulation: [List Side Effects].
- [] **Narrow Therapeutic Index:** This medication has a narrow therapeutic index, and any variation in bioavailability between generic manufacturers poses a significant clinical risk to the patient.
- [] **Excipient Allergy:** The generic formulation contains inactive ingredients (dyes, fillers, or binders) to which the patient has a documented allergy/sensitivity: [List Inactive Ingredient].

Provider Documentation:

[Insert additional clinical notes or history here].

Based on the patient's medical history and the clinical evidence provided, I am requesting that you approve the use of the brand-name medication as medically necessary. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

NPI Number: [NPI Number]

Clinic Name: [Clinic/Facility Name]

Phone: [Phone Number]

Fax: [Fax Number]