Date: [Insert Date]

To: [Insurance Company Name / Medical Director]
Department: [Prior Authorization Department]
Fax/Address: [Insert Fax Number or Address]

RE: Authorization Request for Maintenance Intravenous Therapy

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [ID Number]
Diagnosis: [ICD-10 Code and Disease Name]

To Whom It May Concern,

I am writing to request medical authorization for continued maintenance intravenous (IV) therapy for the above-named patient. The patient has been diagnosed with [Name of Chronic Illness], which requires ongoing clinical intervention to manage symptoms and prevent disease progression.

The requested treatment plan is as follows:

- Medication Name: [Insert Drug Name]
- Dosage: [Insert Dose, e.g., 5mg/kg]
- Frequency: [Insert Interval, e.g., Every 4 weeks]
- Place of Service: [Outpatient Clinic Name]
- Duration: [Requested Length of Authorization, e.g., 12 months]

This patient has previously responded well to this regimen. Maintenance therapy is medically necessary to maintain the patient's current functional status and avoid acute exacerbations that would lead to emergency department visits or hospitalization. Clinical notes and recent lab results are attached to support this request.

Please provide a determination regarding this authorization at your earliest convenience. If you require additional information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Clinic/Practice Name]