

Date: [Date]

TO: [Workers' Compensation Carrier/Adjuster Name]

ATTN: [Adjuster Name]

FAX/EMAIL: [Fax Number or Email Address]

RE: Medication Authorization Request

CLAIMANT: [Patient Name]

CLAIM NUMBER: [Claim Number]

DATE OF INJURY: [Date of Injury]

To Whom It May Concern,

I am the treating physician for [Patient Name] regarding the industrial injury sustained on [Date of Injury]. I am requesting prior authorization for the following compounded medication:

Medication Formula: [List Active Ingredients and Concentrations]

Quantity: [e.g., 120 grams]

Refills: [Number of Refills]

Directions: [e.g., Apply to affected area three times daily]

Medical Necessity:

The patient has been diagnosed with [Diagnosis/ICD-10 Code]. Conventional FDA-approved commercially available medications have been tried and failed, specifically [List Previous Medications Tried]. A compound is medically necessary because [Provide Reason, e.g., patient requires specific dosage, allergy to dyes/fillers, or need for topical application to avoid systemic side effects].

This medication is essential to the patient's treatment plan to manage pain, improve functionality, and facilitate a return to work. Please provide a written authorization or a pharmacy processing number (BIN/PCN) within [Number] days to ensure there is no disruption in care.

If you have any questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Practice Name]

[NPI Number]