

**DATE:** [Date]

**TO:** [Pharmacy Name / Pharmacy Benefit Manager]

**ATTN:** Specialty Pharmacy Department

**FAX:** [Fax Number]

**RE:** Authorization for Specialty Medication

**PATIENT INFORMATION:**

**Name:** [Patient Name]

**Date of Birth:** [DOB]

**Claim Number:** [Claim Number]

**Date of Injury:** [Date of Injury]

**PRESCRIBER INFORMATION:**

**Physician Name:** [Physician Name]

**NPI Number:** [NPI Number]

**Phone:** [Phone Number]

**MEDICATION REQUESTED:**

**Drug Name:** [Drug Name and Strength]

**Dosage/Frequency:** [Instructions]

**Quantity:** [Quantity/Days Supply]

**Refills:** [Number of Refills]

**AUTHORIZATION DETAILS:**

The medication listed above is hereby authorized for the treatment of a work-related injury under the Workers' Compensation claim referenced above. This authorization is valid for the period of [Start Date] to [End Date].

Please process this prescription through the following insurance/billing entity:

**Insurance Carrier:** [Carrier Name]

**Billing Address:** [Address]

**Adjuster Name:** [Adjuster Name]

**Adjuster Phone:** [Adjuster Phone]

For any questions regarding clinical necessity or billing protocols, please contact the undersigned immediately.

Sincerely,

[Signature]

[Printed Name and Title]

[Company/Organization Name]