Prior Authorization Request

Patient Name: John Doe

Patient Address: 123 Main St, Anytown, ST 12345

Patient Insurance ID: ABC123456

Prescribing Physician: Dr. Jane Smith

Physician Contact: (555) 123-4567

Date: [Insert Date]

To Whom It May Concern:

I am writing to request prior authorization for the prescription medication **[Medication Name]** for my patient, John Doe, who has been diagnosed with **[Diagnosis]**.

Medication Details:

Medication Name: [Medication Name]

Dosage: [Dosage]

Quantity: [Quantity]

Frequency: [Frequency]

Clinical Justification:

[Provide a brief explanation of why this medication is necessary for the patient's treatment, including any previous treatments attempted and the outcomes]

Supporting Documentation:

Attached to this letter are the following documents to support the request:

- Patient's medical history
- Lab results
- Previous medication history

Thank you for your consideration of this prior authorization request. Please do not hesitate to contact me at (555) 123-4567 if you need any further information.

Sincerely,

Dr. Jane Smith

[Physician's Practice Name]

[Practice Address]

[Practice Phone Number]