Prior Authorization Request for Medication Approval

To: [Insurance Company Name]

From: [Your Name]

Date: [Date]

Patient Name: [Patient's Name]

Patient ID: [Patient's ID]

Medications Requested: [Medication Name & Dosage]

Prescribing Physician: [Physician's Name]

Diagnosis: [Diagnosis Details]

Clinical Rationale: [Brief explanation of why the medication is necessary]

Previous Treatments: [List any previous treatments and responses]

Attachments: [Any applicable medical records or documentation]

Thank you for considering this request. Please contact me at [Your Phone Number] or [Your Email] if you need any further information.

Sincerely,

[Your Name]
[Your Title/Position]
[Your Organization]