Prior Authorization Request

Date: [Insert Date]

To: [Insurance Company Name]

Attention: Prior Authorization Department

Address: [Insurance Company Address]

Patient Name: [Patient Name]

Patient ID: [Patient ID Number]

Date of Birth: [Patient Date of Birth]

Dear Prior Authorization Specialist,

I am writing to request prior authorization for the following specialty medication:

Medication Name: [Medication Name]

Dosage: [Dosage Information]

Frequency: [Frequency of Administration]

This medication is medically necessary due to [brief explanation of the patient's diagnosis and the rationale for the medication].

Attached are the relevant clinical documents supporting this request, including:

- Patient's medical history
- Clinical notes
- Relevant lab results

Thank you for your prompt attention to this matter. Please do not hesitate to contact me at [Your Contact Information] if you require any additional information.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]

[Your Contact Information]