[Physician Practice letterhead]
[Date]

[Name of insurance company]
[Address]
[City, State, ZIP code]

Re: [Patient's name]
[Policy number]
[Date of birth]

To whom it may concern:

This letter is being submitted for the prior authorization of [PRODUCT NAME] for [insert patient's name]. The authorization requested is for the current date of [date] through the date of [future date].

[If patient is already taking another brand for their treatment, consider including information outlining the severity of their condition at the time of their first prescription. Medical records may need to be pulled from past dates to capture information relevant to their treatment.

If you are addressing a step edit requirement, add a statement about why the required step therapies are not feasible for this patient and why you are requesting the step therapy requirement be eliminated.]

Listed below are my patient's diagnosis, medical history, treatment plan, and other supporting information, which confirm the medical necessity and appropriateness of [PRODUCT NAME].

**Patient's diagnosis, medical history, treatment plan, and other supporting information**

[Insert information regarding the patient's diagnosis; medical history, including previous therapies and results if applicable; treatment plan; and other supporting information.]

The ordering physician is [physician name, NPI #]. The PA decision may be faxed to [fax #] or mailed to [physician business office address]. Please also send a copy of the coverage determination decision to [patient name].

Sincerely,
[Sign and print your name here]

Attachments: [Enclose supporting documentation]