This Example Letter is for demonstration purposes only. Use of this Example Letter or the information in this Example Letter does not guarantee coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.

<Date>
ATTENTION: <Medical Director Name and/or Medical Review/Appeals>
<Payer/Health Plan Name>
<Payer Address>

REGARDING: Prior Authorization for <Product Name>
PATIENT NAME: <Patient Name>
DATE OF BIRTH: <Patient Date of Birth>
POLICY ID NUMBER: <Policy ID Number>
PROVIDER ID NUMBER: <Provider ID Number>

Dear <Medical Director Name and/or Medical Review/Appeals>:

I am writing to request authorization for <Product Name> for my patient, <Patient Name>. I have prescribed <Product Name> because this patient has been diagnosed with <diagnosis>, and I believe that therapy with <Product Name> is appropriate for this patient. Attached to this request are clinical notes regarding this patient's disease state <list any other relevant supporting documentation, as applicable>. Consider attaching the following documents as appropriate: US Food and Drug Administration (FDA) approval letter (if Product was recently approved and/or has not yet been added to the payer's formulary), <Product Name> Prescribing Information, and any documentation related to the patient's disease state, relevant testing, and/or treatment for the patient's condition.

<Product Name> is indicated for <indication from Prescribing Information>.

<Rationale for treating the patient with <Product Name>. In this rationale, you may wish to include patient's diagnosis and disease state, including any therapies the patient is currently using or has previously used, and contraindications to other relevant therapies; comorbid health issues; and any other factors that have influenced your treatment decision. A statement of medical necessity may also be required to obtain a prior authorization.>

Thank you for taking the time to read this letter. I look forward to your prompt review of this request. My office may be reached at <office phone number> if any additional information is required.

Best regards,
<Healthcare Provider Signature>
<Healthcare Provider Name>