[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]

Subject: Request for Coverage Authorization for Prescription Medication

Dear [Insurance Provider/Pharmacy Benefit Manager Name],

I am writing to request prior authorization for the prescription medication [Medication Name] for my patient, [Patient's Name], [Patient's Date of Birth], [Patient's Policy Number].

Clinical information supporting this request includes:

- Diagnosis: [Diagnosis]
- Prescribing Physician: [Physician's Name]
- Relevant Medical History: [Brief summary of medical history that necessitates the medication]
- Treatment Plan: [Outline of the treatment plan and why this medication is essential]

Attached are the relevant medical records and supporting documents for your review.

We appreciate your prompt attention to this matter, as [Patient's Name] requires this medication for [reason]. Please feel free to contact me at [Your Phone Number] or [Your Email Address] if you need further information.

Thank you for your assistance.

Sincerely,
[Your Name]
[Your Title/Position]
[Your Practice/Organization Name]