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

Subject: Prescription Authorization Request for [Patient's Name]

Dear [Claims Adjuster's Name or "To Whom It May Concern"],

I am writing to request prior authorization for the prescription medication [Medication Name] for my patient, [Patient's Name], whose insurance ID is [Patient's Insurance ID].

[Provide a brief description of the patient's medical condition and the reason for the medication request.]

The specific details are as follows:

- Patient Name: [Patient's Name]
- Date of Birth: [Patient's DOB]
- Insurance ID: [Patient's Insurance ID]
- Prescriber Name: [Prescriber's Name]
- Medication: [Medication Name]
- Dosage: [Dosage Information]
- Diagnosis: [Relevant Diagnosis/ICD-10 Code]

[Include any relevant supporting information, such as previous treatments, failed therapies, or clinical trial details.]

Enclosed are copies of [any supporting documents, lab results, or previous authorization requests relevant to this case].

Thank you for your prompt attention to this matter. I appreciate your support in ensuring that [Patient's Name] receives the necessary medication for their treatment.

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