[Your Name]
[Your Title]
[Your Organization/Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]
[Date]
[Insurance Company Name]
[Pharmacy Benefits Manager Name]
[Address]
[City, State, Zip Code]
Subject: Non-Formulary Prescription Authorization Request for [Patient's Name]
Dear [Insurance Company/Pharmacy Benefit Manager Name],
I am writing to request prior authorization for the non-formulary medication [Medication Name] for my patient, [Patient's Full Name], who has been under my care since [Date]. The medication is indicated for [specific diagnosis or condition], and I believe it is crucial for [Patient's Name] due to [explanation of the patient's condition, previous treatments tried, and reasons for the need for this specific medication].
Patient Details:
- Patient's Date of Birth: [DOB]
- Policy Number: [Policy Number]
- Member ID: [Member ID]
Clinical Justification:
[Provide detailed clinical rationale for the use of the requested medication, including any previous treatments/medications that have been ineffective or caused adverse effects.]
I have attached the following documentation to support this request:
- Medical records
- Previous treatment history
- Relevant lab results or imaging
- Any additional supporting documents
I appreciate your prompt attention to this matter and look forward to your positive response. Please feel free to contact me at [Your Phone Number] or [Your Email Address] if you require any additional information.
Thank you for your cooperation.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Credentials]
[Your Organization/Practice Name]