[Your Name]
[Your Title]
[Your Practice/Organization Name]
[Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Claims Department/Specific Department]
[Insurance Company Address]
[City, State, Zip Code]
RE: Off-Label Prescription Authorization Request
Patient Name: [Patient's Full Name]
Date of Birth: [Patient's DOB]
Policy Number: [Patient's Policy Number]
Claim Number: [Claim Number, if applicable]
Dear [Insurance Company Representative/Specific Contact Name],
I am writing to request prior authorization for an off-label prescription for my patient, [Patient's Full Name], who is under my care for [Diagnosis/Condition].
After thorough assessment and consideration, I believe that [Medication Name], prescribed at [Dosage] for [Indication/Reason] is clinically appropriate for this patient. The evidence supporting the use of this medication includes [Brief Summary of Clinical Evidence or Guidelines Supporting the Use].
Given the patient's medical history and the current state of their health, I am confident that this treatment will significantly improve [his/her/their] condition and quality of life.
Please find attached the necessary documentation, including [List of Documents - e.g., clinical notes, relevant studies, etc.].
I appreciate your prompt attention to this matter and look forward to your positive response. Should you require any further information, please do not hesitate to contact me at [Your Phone Number] or [Your Email Address].
Thank you for your consideration.
Sincerely,
[Your Signature (if sending a hard copy)]
[Your Printed Name]
[Your Title]
[Your Practice/Organization Name]