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

Subject: Request for Prior Authorization for [Medication Name]

Dear [Insurance Company/Pharmacist's Name],

I am writing to formally request prior authorization for the medication [Medication Name], prescribed by [Prescribing Physician's Name] on [Date of Prescription]. The patient's details are as follows:

- Patient's Name: [Patient's Name]
- Patient's Date of Birth: [Patient's Date of Birth]
- Patient's Policy Number: [Policy Number]

[Include a brief description of the patient's medical condition and the reason for the prescribed medication. Discuss previous treatments and their outcomes if applicable.]

[Medication Name] is necessary for the effective management of [specific condition], and it is proven to [include any relevant clinical information or guidelines supporting the use of the medication].

Attached are the following supporting documents:

1. Copy of the prescription
2. Medical history
3. Relevant lab results/test records
4. Previous treatment records

Thank you for considering this request. Please feel free to contact me at [Your Phone Number] or [Your Email Address] for any further information or clarification.

Sincerely,
[Your Name]
[Your Title/Relationship to Patient, if applicable]
[Your Practice/Institution Name, if applicable]