[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
Subject: Pre-Authorization Request for Xolair
Dear [Insurance Company Representative/Department Name],
I am writing to request pre-authorization for the medication Xolair (omalizumab) for my patient, [Patient's Name], who has been diagnosed with [specific diagnosis].
Patient Information:
- Patient Name: [Patient's Full Name]
- Date of Birth: [Patient's Date of Birth]
- Insurance ID Number: [Patient's Insurance ID Number]
Clinical Background:
[Provide a brief summary of the patient's medical history, diagnosis, and why Xolair is indicated. Include relevant treatment history and failed therapies, if applicable.]
Proposed Treatment:
- Medication: Xolair (omalizumab)
- Dosage: [Proposed dosage]
- Frequency: [Proposed administration schedule]
Supporting Documentation:
I have included the following documents to support this request:
- [List any attached documents, such as medical records, lab results, or previous treatment responses.]
I believe that Xolair is medically necessary for my patient, and I respectfully request your prompt attention to this matter. Please feel free to contact me at [Your Phone Number] or [Your Email Address] should you require any additional information.
Thank you for your consideration.
Sincerely,
[Your Name]
[Your Professional Title]
[Your Practice/Facility Name]
[Your NPI Number if applicable]