[Your Name]
[Your Address]
[City, State, ZIP Code]
[Email Address]
[Phone Number]
[Date]
[Insurance Company Name]
[Insurance Company Address]
[City, State, ZIP Code]
Subject: Prior Authorization Request for Xtandi
Dear [Insurance Company's Prior Authorization Department],
I am writing to request prior authorization for the medication Xtandi (enzalutamide) for my patient, [Patient's Name], [Patient's Date of Birth], [Insurance ID Number]. This request is based on my clinical assessment and the necessity of this treatment for the patient's specific condition.
Patient Diagnosis:
[State the diagnosis relevant to the use of Xtandi, e.g., metastatic castration-resistant prostate cancer.]
Clinical Rationale:
[Provide a brief explanation of why Xtandi is the appropriate therapy for the patient, including relevant medical history and previous treatments tried, if any.]
Treatment Plan:
- Medication: Xtandi
- Dosage: [Specify dosage]
- Duration: [Specify duration of treatment]
Supporting Information:
[Include any relevant test results, treatment history, or supporting documents that confirm the need for Xtandi.]
I appreciate your prompt attention to this matter, as timely treatment is crucial for the management of my patient's condition. Should you need 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 Name]
[Your Title/Position]
[Your Medical Institution/Practice Name]
[Your NPI Number]