[Physician's Name/Clinic Letterhead]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

To [Name of Organization/Recipient],

RE: Medication Exemption Request for [Patient Name]
DOB: [Patient Date of Birth]

To Whom It May Concern,

I am writing this letter in support of [Patient Name]'s request for a medical exemption regarding [Specific Policy or Requirement, e.g., Employer Drug Testing/Travel Restriction/Formulary Restriction].

[Patient Name] is currently under my care for the treatment of [Medical Condition]. As part of their prescribed treatment plan, I have ordered the following medication:

Medication Name: [Name of Medication]
Dosage/Frequency: [Dosage Information]
Start Date: [Date Started]

This medication is medically necessary for the management of the patient's condition. Alternative treatments have been [considered/exhausted] and were found to be [ineffective/inappropriate] for this specific case. Stopping or altering this medication would likely result in [brief description of negative health impact].

I request that you grant [Patient Name] an exemption based on these medical requirements. If you require further clinical documentation or have any questions, please contact my office directly at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical License Number]
[Clinic Name]