Date: [Insert Date]

Patient Name: [Insert Child's Full Name]
Date of Birth: [Insert Date of Birth]
Medical Record Number: [Insert MRN]

To: [Insert Name of Insurance Company, Pharmacy, or School District]

Subject: Authorization for Off-Label Use of [Insert Medication Name]

To Whom It May Concern,

I am writing to formally authorize and document the medical necessity for the off-label use of **[Insert Medication Name]** for my patient, **[Insert Patient Name]**. This medication is being prescribed to treat **[Insert Diagnosis/Condition]**.

While this medication is currently FDA-approved for [Insert FDA Approved Use], clinical evidence and professional guidelines support its use for [Insert Patient's Condition] in pediatric patients. In my professional medical judgment, the benefits of this treatment outweigh the potential risks, and alternative FDA-approved treatments have been [exhausted/deemed inappropriate] for the following reasons:

- [Reason 1: e.g., Lack of efficacy of standard treatments]
- [Reason 2: e.g., Specific clinical presentation of the patient]
- [Reason 3: e.g., Supporting peer-reviewed clinical studies]

I have discussed the nature of this "off-label" use with the patient's legal guardians, including potential side effects and the rationale for this specific treatment plan. Informed consent has been obtained and is documented in the patient's medical record.

Please process any necessary [prior authorizations/dispensing requirements] to ensure the patient has uninterrupted access to this therapy.

Sincerely,

[Physician Signature]
Physician Name: [Insert Name]
Medical License Number: [Insert License #]
NPI Number: [Insert NPI #]
Clinic Name: [Insert Clinic/Hospital Name]
Phone Number: [Insert Phone Number]