

**Date:** [Insert Date]

**To:** Clinical Staff and Pharmacy Department

**From:** [Name of Authorizing Medical Director/Chief Medical Officer]

**Subject:** Internal Authorization for Off-Label Protocol Use

This letter serves as formal internal authorization for the administration of [Name of Medication/Treatment] for the treatment of [Specific Condition/Indication] within [Name of Clinic/Facility].

While the aforementioned treatment is currently FDA-approved for [Standard Indication], recent clinical data and peer-reviewed evidence support its off-label use for [Specific Condition]. After a thorough clinical review, it has been determined that this protocol is medically necessary for the following patient population: [Describe Patient Criteria].

**Protocol Requirements:**

- **Informed Consent:** A signed off-label use consent form must be obtained from each patient prior to treatment.
- **Monitoring:** Patients must be monitored according to the schedule outlined in [Internal Protocol Reference Number].
- **Documentation:** All clinical outcomes and any adverse events must be documented in the Electronic Health Record (EHR).

This authorization is effective as of [Start Date] and will remain in effect until [End Date/Further Notice]. All staff members participating in this protocol must adhere to the established clinical guidelines.

Approved by:

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[Signature]  
[Printed Name]  
[Title/Medical License Number]  
[Clinic Name]