[Physician Name/Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

To: [Patient Assistance Program Name]
[Program Address]
[City, State, Zip Code]

RE: Prescription Authorization for [Patient Full Name]
Date of Birth: [Patient DOB]
Patient ID/Case Number (if applicable): [ID Number]

To Whom It May Concern,

I am writing to authorize the enrollment of my patient, **[Patient Full Name]**, into the **[Program Name]** for the following medication(s):

- **Medication Name:** [Drug Name]
- **Dosage:** [e.g., 20mg]
- **Frequency:** [e.g., Once Daily]
- **Quantity:** [e.g., 90-day supply]
- **Refills:** [Number of refills]

Diagnosis: [Diagnosis Name/ICD-10 Code]

I certify that the medication listed above is medically necessary for this patient's treatment plan. The patient is under my direct care, and I will continue to monitor their condition throughout the duration of this therapy.

I hereby authorize the [Program Name] and its representatives to dispense the medication as prescribed and to contact my office should further clinical documentation be required.

Thank you for your assistance in providing this necessary treatment for my patient.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[NPI Number]
[State License Number]