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

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

RE: Prescription Authorization for [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Insurance ID: [Insurance ID Number, if applicable]

To Whom It May Concern,

I am writing to authorize the enrollment of my patient, [Patient Full Name], into the [Program Name] for assistance with their chronic illness medication. [Patient Name] has been under my care since [Date] and has been diagnosed with [Chronic Illness Diagnosis].

As part of their treatment plan, I have prescribed the following medication(s):

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

This medication is medically necessary for the management of the patient's chronic condition. Due to the long-term nature of this illness and the associated costs of treatment, I strongly support the patient's application for financial or medication assistance.

Please find the attached prescription(s) and any required clinical documentation. If you require additional information regarding this patient's diagnosis or treatment history, please contact my office at [Phone Number].

Thank you for your assistance in ensuring my patient has access to their required therapy.

Sincerely,

[Physician Signature]

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