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

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

RE: Urgent Prescription Authorization for [Patient Name]
Date of Birth: [Patient DOB]
Medication: [Medication Name and Dosage]

To Whom It May Concern,

I am writing to formally request an expedited authorization for [Patient Name] to participate in your Patient Assistance Program for [Medication Name].

The patient has been diagnosed with [Diagnosis/Condition] and this medication is medically necessary for their treatment. Due to [Reason for Urgency: e.g., immediate risk of hospitalization, depletion of current supply, or severe symptom progression], the patient requires access to this medication within [Number] hours/days to avoid serious health complications.

Current clinical status: [Briefly describe patient's urgent need].

Please find the attached prescription and any required medical documentation. I certify that the information provided is accurate and that this patient meets the clinical criteria for this treatment. Given the urgency of this request, please process this application as a priority.

If you require additional information, please contact my office immediately at [Phone Number].

Sincerely,

[Physician Signature]

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