[Date]

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

RE: Prescription Authorization for Patient Assistance Program

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Insurance ID (if applicable): [ID Number]
Medication Requested: [Medication Name and Dosage]

To Whom It May Concern,

I am writing to authorize and request the enrollment of the above-named patient into your Patient Assistance Program (PAP). As the patient's prescribing physician, I have determined that this specialty medication is medically necessary for the treatment of [Diagnosis/ICD-10 Code].

The patient currently lacks adequate prescription drug coverage or the financial means to afford the out-of-pocket costs associated with this therapy. I certify that the medication provided through this program will be used solely for the treatment of this patient and will not be resold or offered for sale.

Prescription Details:

- **Medication:** [Name/Strength]
- **Directions:** [Sig/Instructions]
- **Quantity:** [Amount]
- **Refills:** [Number of Refills]

Please find the completed application form and supporting clinical documentation attached. Please notify my office of the enrollment status and the expected shipping date for the medication.

Thank you for your assistance in ensuring this patient receives their required treatment.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Clinic/Hospital Name]
[Phone Number]
[Fax Number]