[Physician Name/Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

[Pharmaceutical Program Name]
[Program Address]
[City, State, Zip Code]

RE: Financial Hardship Patient Assistance Program Authorization
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Medication Requested: [Medication Name and Dosage]

To Whom It May Concern,

I am writing to formally request enrollment for my patient, [Patient Name], into your Patient Assistance Program (PAP). I have diagnosed the patient with [Diagnosis/ICD-10 Code] and have determined that [Medication Name] is medically necessary for their ongoing treatment.

The patient is currently experiencing significant financial hardship. [Optional: Briefly describe situation, e.g., lack of insurance, high deductible, or limited income]. Due to these financial constraints, the patient is unable to afford the out-of-pocket costs for this life-sustaining medication. Without assistance from your program, the patient will be unable to maintain treatment compliance, which may lead to a severe decline in their health status.

I certify that the information provided in this application is accurate to the best of my knowledge and that the medication will be used only for the patient named above. Included with this letter are the required clinical documents and the patient's signed application form.

Thank you for your time and for providing this essential resource to patients in need. Please contact my office at [Phone Number] if you require any further information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[Tax ID Number]