Date: [Insert Date]

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

Re: Coverage Gap Patient Assistance Authorization

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Insurance ID: [Insurance Member ID]
Prescription Number: [RX Number, if applicable]

To Whom It May Concern,

I am writing to authorize the enrollment of my patient, [Patient Name], into your Patient Assistance Program. The patient has entered the Medicare Part D "Coverage Gap" (Donut Hole) and is currently facing a financial hardship that limits their ability to afford their prescribed medication.

Prescription Information:

- **Medication Name:** [Drug Name]
- **Dosage:** [Strength/Frequency]
- **Diagnosis:** [ICD-10 Code / Diagnosis Description]

I certify that this medication is medically necessary for the treatment of the patient's condition. I request that the patient be granted access to the assistance program to ensure medication adherence and prevent complications arising from a lapse in therapy.

Attached to this letter, please find the required medical documentation and a copy of the patient's current prescription.

Thank you for your assistance in providing this life-sustaining medication.

Sincerely,

[Physician Signature]
Provider Name: [Physician Full Name]
NPI Number: [Provider NPI]
Clinic/Hospital: [Facility Name]
Phone Number: [Phone Number]