Date: [Insert Date]

To: [Insert Patient Assistance Program Name]
Address: [Insert Program Address]
Fax/Email: [Insert Contact Information]

RE: Prescription Authorization and Medical Necessity

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Patient Date of Birth]
Guardian Name: [Insert Parent/Guardian Name]
Policy/ID Number: [Insert ID Number, if applicable]

To Whom It May Concern,

I am writing to authorize and request assistance for the following medication prescribed for my pediatric patient, [Patient Name]:

Medication Name: [Insert Drug Name]
Dosage: [Insert Strength/mg]
Frequency: [Insert How Often Taken]
Quantity: [Insert Supply Duration, e.g., 90-day supply]

Diagnosis: [Insert ICD-10 Code and Description]
Clinical Justification: [Briefly describe why this medication is necessary for the child's health and the failure of previous treatments, if applicable].

I certify that I am the treating physician for this patient and that the information provided is medically necessary for their ongoing care. I request that [Patient Name] be enrolled in your Patient Assistance Program to ensure uninterrupted access to this therapy.

Please find the attached prescription and any required clinical documentation. If you require further information, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Insert Full Name]
NPI Number: [Insert NPI Number]
Clinic/Hospital Name: [Insert Facility Name]
Address: [Insert Facility Address]