[Patient Full Name]
[Patient Address]
[City, State, Zip Code]
[Patient Phone Number]
[Date]

To: [Name of Patient Assistance Program/Pharmaceutical Company]
[Program Address]
[City, State, Zip Code]

Subject: Authorization for Prescription Refill and Program Participation

To Whom It May Concern,

I, [Patient Full Name], born on [Date of Birth], am writing to formally authorize the request for a prescription refill through the [Name of Patient Assistance Program].

I am currently under the care of [Physician Name] at [Clinic/Hospital Name] for the treatment of [Condition]. I have been prescribed [Medication Name, Strength, and Dosage] and require a refill to ensure continuity of my treatment.

By signing this letter, I grant permission for the following:

- The [Name of Patient Assistance Program] to process my refill request.
- My healthcare provider and pharmacy to release necessary medical and insurance information to the program administrators.
- The program to ship the medication to my home address or my physician's office as specified in the program guidelines.

I confirm that my financial status and insurance coverage have not significantly changed since my last application, and I still meet the eligibility requirements for this program. (If changes have occurred, please specify: [Optional: Brief description of changes]).

Please find the attached prescription from my physician. If you require further documentation or have any questions, please contact me at [Phone Number] or my physician's office at [Physician Phone Number].

Thank you for your continued assistance in providing my necessary medication.

Sincerely,

[Patient Signature]
[Patient Printed Name]

Physician Attestation (Optional if required by program):
I confirm that the patient named above requires the medication listed and remains under my

medical supervision.

[Physician Signature]: _____
[Physician Name and NPI]: _____