Date: [Insert Date]

To: [Pharmacist/Provider Name]
Facility: [Pharmacy/Clinic Name]
Address: [Pharmacy Address]

Subject: Temporary Prescription Authorization - Patient Assistance Program

Dear Pharmacist,

This letter serves as formal notification that **[Patient Name]** (DOB: [Date of Birth]) has been approved for temporary medication coverage through the **[Program Name]**. This authorization is granted while the patient awaits final processing of their long-term enrollment.

Authorization Details:

- **Medication Name:** [Drug Name and Strength]
- **Dosage/Frequency:** [Instructions]
- **Authorization Number:** [ID Number]
- **Effective Dates:** [Start Date] to [End Date]

Please dispense a **[Number, e.g., 30]** day supply of the aforementioned medication. The costs associated with this fill should be billed to:

Billing Information:
BIN: [Insert BIN]
PCN: [Insert PCN]
Group: [Insert Group ID]
Member ID: [Insert Temporary ID]

If you encounter any issues processing this claim, please contact our program coordinator immediately at [Phone Number].

Sincerely,

[Your Name/Signature]
[Title/Position]
[Organization Name]