Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Insurance Group/ID: [ID Number]

To: [Name of Patient Assistance Program/Pharmaceutical Company]
Program Name: [Program Name, e.g., Patient Access Support]

Subject: Medical Necessity and Prescription for [Medication Name]

To Whom It May Concern,

I am writing to formally request enrollment for my patient, [Patient Name], into your Patient Assistance Program for the medication **[Medication Name]**. The patient has been diagnosed with [Diagnosis/ICD-10 Code] and requires this high-cost therapy for the management of their condition.

Prescription Details:

- **Medication:** [Medication Name and Strength]
- **Dosage:** [Dosage Instructions]
- **Quantity:** [e.g., 30-day supply]
- **Refills:** [Number of Refills]

Clinical Justification:
The patient has previously tried and failed the following therapies: [List previous medications]. Due to the high cost of [Medication Name] and the patient's current financial hardship/insurance coverage gap, they are unable to afford this life-sustaining treatment without your assistance.

Attached please find the completed application form and required clinical documentation. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
Physician Name: [Name, Title]
NPI Number: [NPI Number]
Clinic Name: [Clinic/Hospital Name]
Address: [Street, City, State, Zip]