[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Name of Patient Assistance Program]
[Program Address]
[City, State, Zip Code]

RE: Appeal for Prescription Authorization
Patient Name: [Patient Full Name]
Application/Member ID: [ID Number, if applicable]
Medication Name: [Name of Medication]

To Whom It May Concern,

I am writing to formally appeal the denial of my application for the [Name of Patient Assistance Program] regarding the medication [Medication Name]. I received a notification of denial on [Date of Denial Letter] stating the reason for denial was [Reason stated in the letter].

I am requesting a reconsideration of this decision based on the following information:

[Explain your situation: e.g., "My financial circumstances have changed," "I do not have insurance coverage for this specific drug," or "My out-of-pocket costs exceed my monthly income."]

Attached to this letter, please find supporting documentation to verify my eligibility:

- [List document 1: e.g., Recent Tax Returns/W-2]
- [List document 2: e.g., Proof of current income/Pay stubs]
- [List document 3: e.g., Letter of Medical Necessity from Physician]
- [List document 4: e.g., Pharmacy records of high out-of-pocket costs]

This medication is essential for managing my condition, [Name of Condition]. Without the support of your program, I will be unable to afford this life-sustaining treatment.

Thank you for your time and for reconsidering my application. I look forward to your positive response. Please contact me at [Phone Number] if you require any further information.

Sincerely,

[Your Signature]
[Your Printed Name]