

[Physician Name]
[Institution/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

[Date]

[Pharmaceutical Company Name]
[Contact Person/Department]
[Address]
[City, State, Zip Code]

Subject: Request for Compassionate Use / Expanded Access for [Investigational Drug Name]

Dear [Contact Name or Medical Director],

I am writing to formally request expanded access (compassionate use) to your investigational product, [Drug Name], for my patient, [Patient Name/ID], who is suffering from [Specific Disease or Condition].

Clinical Justification:

The patient is a [Age]-year-old [Male/Female] diagnosed with [Disease] in [Year]. The patient's current condition is [Serious/Life-threatening]. To date, the patient has undergone the following treatments: [List previous therapies]. Unfortunately, these treatments have [failed/been poorly tolerated], and there are currently no comparable or satisfactory alternative therapies available to treat the patient's condition.

Rationale for Use:

Based on [mention clinical trials or published data], I believe that [Drug Name] may offer a potential clinical benefit to this patient. The probable risk from the investigational drug is not greater than the probable risk from the disease itself.

Treatment Plan:

If access is granted, I intend to administer [Drug Name] according to the following protocol: [Dose, Frequency, and Duration]. I will monitor the patient closely for safety and efficacy, and I will report all adverse events to [Company Name] and the relevant Institutional Review Board (IRB).

Physician Statement:

I am a licensed physician in [State/Country] and am qualified to administer this treatment. I agree to comply with all FDA/Regulatory requirements regarding expanded access, including obtaining informed consent and maintaining accurate records.

Thank you for your consideration of this urgent request. I look forward to your timely response.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]