[Physician Name]
[Medical Institution/Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Email Address]
[Phone Number]

[Date]

[Name of Pharmaceutical Company/Manufacturer]
[Attention: Expanded Access Program Department]
[Address Line 1]
[City, State, Zip Code]

RE: Compassionate Use Request for [Patient Name] (DOB: [MM/DD/YYYY])

Dear [Contact Name or Department],

I am writing to formally request compassionate use access (expanded access) to [Name of Investigational Drug/Treatment] for my patient, [Patient Name], who is diagnosed with [Name of Rare Disease].

The patient is currently suffering from a serious and life-threatening condition for which there are no comparable or satisfactory alternative treatments available. [Patient Name] has previously tried [List previous treatments/medications] without success or with intolerable side effects. Based on current clinical data, I believe the potential benefits of [Investigational Drug] outweigh the potential risks in this specific case.

I confirm the following regarding this request:

- The patient does not meet the eligibility criteria for current clinical trials or is unable to participate due to [Reason, e.g., geographic location or trial closure].
- I am a licensed physician qualified to administer this treatment and monitor the patient.
- I agree to comply with all regulatory requirements, including Institutional Review Board (IRB) approval and reporting of adverse events to the FDA and [Company Name].

Please find attached the patient's medical summary and the proposed treatment plan. I am available to discuss this request further at your earliest convenience.

Thank you for your time and consideration of this urgent request.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]