[Your Name]
[Your Address]
[Your Phone Number]
[Your Email]

[Date]

[Physician Name or Pharmacy Benefits Manager]
[Organization Name]
[Address]

Re: Request for Medication Cost Assistance for [Medication Name]

Dear [Name of Physician or Representative],

I am writing to formally request assistance in reducing the out-of-pocket cost for my prescribed medication, [Medication Name]. Currently, the cost of this prescription is [Amount] per [Month/Refill], which has become a significant financial burden.

I am committed to following my treatment plan, but the current price is making it difficult for me to remain compliant with my dosage. I would like to explore the following options:

- Prescribing a generic version of this medication.
- Switching to a lower-cost therapeutic alternative.
- Information on Patient Assistance Programs (PAP) or manufacturer coupons.
- A 90-day supply prescription to reduce pharmacy dispensing fees.
- A formal Tier Exception or Prior Authorization request to my insurance provider.

Please let me know which of these options are available or if there are other resources you recommend to help make this life-saving medication more affordable.

Thank you for your time and for your help in managing my health care.

Sincerely,

[Your Signature]

[Your Printed Name]
[Insurance Policy Number, if applicable]