<Medical Facility Letterhead>

<Date>
<Patient>
<DOB>

To Whom It May Concern:

<Name> is under the care of <name of physician or clinic>for a primary immunodeficiency disease. This condition necessitates that <he or she> infuse a medication called <product name>. This medication is available in <list vial sizes>. The supplies for completing this infusion include:

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It is medically necessary for <Name> to carry these supplies at all times. <He or She> should not become separated from this medication or supplies as it is life-saving therapy.

Please call our office if you have any questions.

Sincerely,

<Signature of Medical Professional>
<Name of Medical Professional>
<Title of Medical Professional>
<Address>
<Phone Number>