[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Healthcare Provider's Name]
[Healthcare Provider's Address]
[City, State, Zip Code]

Dear [Healthcare Provider's Name],

I am writing to request assistance with obtaining Xtandi (enzalutamide) for my ongoing treatment. I have been diagnosed with [specific condition] and my doctor, [Doctor's Name], has recommended that I start this medication as part of my treatment plan.

Unfortunately, I am currently facing challenges with the cost of the medication. My insurance plan [insurance plan name] has placed limitations on coverage for Xtandi, which has resulted in [explain specific situation--e.g., high out-of-pocket costs, denial of coverage, etc.].

I am reaching out to explore available patient assistance programs and resources that could help make this medication accessible for me. If possible, I would greatly appreciate any information you could provide regarding financial aid or assistance programs that could support my access to Xtandi.

Thank you for your attention to this matter. I look forward to your prompt response.

Sincerely,
[Your Name]
[Your Signature (if sending a hard copy)]
[Your Date of Birth] (if needed for verification)