

[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

RE: Refill Request for [Medication Name]

Dear [Patient Name],

This letter is to formally notify you that we are unable to fulfill your recent request for a refill of [Medication Name].

Our records indicate that this prescription was last filled on [Date] for a [Number]-day supply. Based on the prescribed dosage, a refill is not due until [Date]. We have noted an excessive number of early refill requests regarding this medication.

For your safety and in compliance with medical guidelines, we cannot authorize refills before the current supply is intended to be finished. Frequent early refills can lead to improper use or potential health risks.

If you believe there is an error in our records, or if your dosage has been adjusted by another provider, please have them contact our office directly. Otherwise, please submit your next refill request no sooner than [Number] days before your current supply is exhausted.

If you are experiencing symptoms that require a change in your treatment plan, please schedule an appointment for a clinical evaluation.

Sincerely,

[Provider Name/Signature]
[Practice Name]