[Date]

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

RE: Denial of Early Refill Request for [Medication Name]

Dear [Patient Name],

We are writing to inform you that your request for an early refill of [Medication Name], originally submitted on [Date], has been denied.

According to our records and the prescription instructions provided by your physician, your current supply is intended to last until [Expected Run-out Date]. Our policy, in alignment with safety guidelines and insurance regulations, requires that [Percentage]% of the previous prescription be consumed before a refill can be authorized.

Strict adherence to the prescribed dosage is essential for your safety and the effectiveness of your treatment. Taking more than the prescribed amount or filling prescriptions too frequently can lead to serious health risks and may be flagged as non-compliance with your treatment plan.

Please note the following:

- The next eligible date for this refill is [Eligible Date].
- If your dosage has been changed by your doctor, please have their office contact us or submit a new prescription immediately.
- If there are extenuating circumstances, such as lost medication or travel, additional documentation may be required for an override.

If you have questions regarding your medication schedule, please contact your healthcare provider. For questions regarding pharmacy policy, you may speak with our pharmacist at [Phone Number].

Sincerely,

[Pharmacist/Provider Name]
[Facility/Pharmacy Name]
[Phone Number]