**Date:** [Date]

**To:** [Pharmacy Name]
**Pharmacy Address:** [Pharmacy Street Address, City, State, Zip Code]
**Pharmacy Phone Number:** [Phone Number]

**Subject: Authorization for Updated Dosage Prescription Refill**

Dear Pharmacist,

I am writing to authorize an updated dosage for the following patient:

**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient DOB]
**Medication Name:** [Medication Name]

**Previous Dosage:** [Old Dosage, e.g., 10mg once daily]
**Updated Dosage:** [New Dosage, e.g., 20mg once daily]

**Reason for Change:** [Optional: Clinical adjustment / Treatment optimization]
**Effective Date:** [Start Date of New Dosage]
**Number of Refills Authorized:** [Number]

Please update the patient's records and dispense the medication according to these new instructions. All previous prescriptions for this medication at the old dosage should be voided.

If you have any questions or require further verification, please contact my office at [Provider Phone Number].

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**
[Practice/Clinic Name]
[NPI Number]
[DEA Number (if applicable)]