Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

To: [Pharmacist Name / Pharmacy Name]

Subject: Notification of Dosage Adjustment for Maintenance Medication

To whom it may concern,

This letter is to formally authorize a change in the maintenance dosage for the patient mentioned above. Please update your records and dispense the following medication as specified:

- **Medication Name:** [Medication Name]
- **Previous Dosage:** [Old Dosage/Frequency]
- **New Adjusted Dosage:** [New Dosage/Frequency]
- **Reason for Change:** [Clinical adjustment / Therapeutic optimization]
- **Effective Date:** [Date]
- **Refills Authorized:** [Number of refills]

The patient has been instructed on the new dosing schedule. Please discontinue any previous refill authorizations associated with the old dosage to ensure patient safety and compliance.

If you have any questions regarding this adjustment, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Clinic/Hospital Name]
[NPI Number / DEA Number]