

**Date:** [Insert Date]

**To:** [Pharmacist Name / Pharmacy Name]

**From:** [Physician/Provider Name]

**Facility:** [Hospital/Clinic Name]

**Subject: AUTHORIZATION FOR AFTER-HOURS EMERGENCY MEDICATION SUPPLY**

To whom it may concern,

I am writing to formally authorize an emergency supply of medication for the following patient due to an urgent medical necessity that has occurred outside of regular business hours.

**Patient Information:**

Patient Name: [Full Name]

Date of Birth: [MM/DD/YYYY]

Patient ID/MRN: [ID Number]

**Medication Details:**

Medication Name: [Name of Drug]

Dosage/Strength: [e.g., 50mg]

Quantity Authorized: [e.g., 3-day supply]

Directions for Use: [e.g., Take one tablet daily]

**Clinical Justification:**

The patient requires this medication immediately to prevent [mention clinical risk, e.g., hospitalization, withdrawal, or exacerbation of condition]. A full prescription will be sent via [e-prescribing/fax] by the next business day.

**Provider Contact Information:**

Phone Number: [Phone Number]

NPI Number: [NPI Number]

DEA Number (if applicable): [DEA Number]

Please dispense the authorized emergency amount to the patient listed above. If you have any questions regarding this authorization, please contact me at the number provided.

Sincerely,

[Signature]

[Printed Name and Title]