[Physician Name/Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]
[Date]

RE: Controlled Substance Prescription Authorization
Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

I am the primary care physician for the patient named above. This letter serves as formal authorization and verification for the medical necessity of the following controlled substance(s) as part of their ongoing treatment plan:

- **Medication Name:** [Medication Name and Strength]
- **Dosage/Frequency:** [e.g., One tablet twice daily]
- **ICD-10 Code/Diagnosis:** [Diagnosis Name/Code]

The patient has been evaluated and is monitored regularly in accordance with state and federal regulations regarding controlled substances. I have reviewed the patient's history and determined that this medication is essential for managing their condition.

This authorization is valid from [Start Date] through [End Date/Next Review Date]. Should you have any questions or require further verification, please contact my office directly.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]
[DEA Number]