

Date: [Date]

TO: [Pharmacy Name / Medical Board]

ATTN: Pharmacist-in-Charge / Medical Reviewer

RE: Controlled Substance Treatment Authorization

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Patient ID/Chart #: [ID Number]

To whom it may concern,

This letter serves as formal authorization and verification that the above-named patient is currently under the active care of [Clinic Name] for the management of chronic pain. As part of their comprehensive treatment plan, the patient has been prescribed the following controlled substance(s):

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

Please be advised of the following clinic protocols:

- The patient has signed a formal Controlled Substance Agreement with this clinic.
- This clinic is the sole prescriber of controlled substances for this patient.
- Regular Prescription Monitoring Program (PMP) checks and urine drug screenings are performed.
- Early refills are not authorized unless explicitly stated by the prescribing physician.

We authorize [Pharmacy Name] to dispense this medication as prescribed. If there are any discrepancies, concerns regarding drug-to-drug interactions, or if the patient attempts to fill prescriptions from other providers, please contact our office immediately.

Sincerely,

[Physician Signature]

[Physician Name, Degree]

DEA Number: [DEA Number]

NPI Number: [NPI Number]

Clinic Name: [Clinic Name]

Phone: [Phone Number]