

**Date:** [Current Date]

**TO:** [Pharmacy Name / Prescription Monitoring Program]

**FROM:** [Physician/Provider Name], [Credentials]

**RE:** Annual Renewal of Controlled Substance Authorization

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**Patient Address:** [Patient Address]

To Whom It May Concern,

This letter serves as formal notification and clinical documentation for the annual renewal of controlled substance prescriptions for the above-named patient. The patient is under my ongoing care for the treatment of [Diagnosis/Condition].

As the prescribing provider, I confirm the following:

- A face-to-face clinical evaluation was conducted on [Date of Last Visit].
- The patient's treatment plan, medication efficacy, and functional goals have been reviewed and updated.
- A review of the state Prescription Drug Monitoring Program (PDMP) has been completed.
- The patient is in compliance with the signed Controlled Substance Agreement on file.
- Annual screening (e.g., urine drug toxicology) was performed on [Date] with satisfactory results.

The following medication(s) are authorized for renewal:

**Medication:** [Medication Name and Strength]

**Dosage/Frequency:** [Instructions]

**Quantity/Days Supply:** [Amount]

This authorization is valid for one year from the date of this letter, subject to scheduled follow-up appointments every [Number] months as per clinic policy and state regulations.

Should you require further verification, please contact my office at [Phone Number].

Sincerely,

[Signature]

[Provider Name, Title]

[DEA Number]

[NPI Number]

[Clinic/Practice Name]