Date: [Insert Date]

To: [Pharmacist Name/Pharmacy Name]
Address: [Pharmacy Address]
Phone: [Pharmacy Phone Number]

RE: AUTHORIZATION FOR DISPENSING COMPOUNDED MEDICATION

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Prescription Number (if known): [Insert Rx Number]

To whom it may concern,

I, [Prescriber Name], acting as the licensed healthcare provider for the aforementioned patient, hereby authorize [Pharmacy Name] to compound and dispense the following medication as prescribed:

Medication Formula/Ingredients:
[List Ingredients and Concentrations]

Dosage Form: [e.g., Cream, Capsule, Suspension]
Quantity: [Insert Quantity]
Directions for Use: [Insert Sig/Instructions]
Refills: [Insert Number of Refills]

I have determined that this compounded medication is medically necessary for the patient because a commercially available FDA-approved product does not meet the specific clinical needs of the patient at this time.

Please contact my office at [Phone Number] if you require any further clarification or documentation.

Sincerely,

[Prescriber Signature]

Prescriber Name: [Print Name]
NPI Number: [Insert NPI]
DEA Number: [Insert DEA, if applicable]
Clinic Name: [Insert Clinic/Practice Name]
Address: [Insert Office Address]