

Date: [Insert Date]

To: [Pharmacy Name]

Pharmacist in Charge: [Name of Pharmacist, if known]

Pharmacy Address: [Insert Address]

RE: Dispensing Authorization for Dermatological Compound

Patient Name: [Insert Patient Full Name]

Date of Birth: [Insert Date of Birth]

Prescription Number: [Insert Rx Number, if available]

To Whom It May Concern,

I, [Physician Name], hereby authorize the dispensing of the following custom dermatological compound for the patient listed above:

Compound Formulation:

[Ingredient 1 and Concentration]

[Ingredient 2 and Concentration]

[Ingredient 3 and Concentration]

[Base/Vehicle Type]

Quantity: [Insert Amount, e.g., 30g, 60ml]

Directions for Use: [Insert Sig, e.g., Apply to affected area twice daily]

Refills Authorized: [Insert Number of Refills]

This compound is medically necessary for the treatment of the patient's dermatological condition. Please ensure the formulation adheres strictly to the concentrations specified above. If any ingredient is unavailable or requires substitution, please contact my office immediately for approval.

Should you have any questions regarding this prescription or the authorization, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

Physician Name: [Insert Printed Name]

NPI Number: [Insert NPI Number]

DEA Number: [Insert DEA Number, if applicable]

Clinic/Practice Name: [Insert Practice Name]