

Date: [Date]

To: [Pharmacy Name]

Address: [Pharmacy Address]

Phone/Fax: [Pharmacy Phone/Fax]

RE: Dispensing Authorization for Compounded Medication

Patient Name: [Patient Full Name]

Date of Birth: [Date of Birth]

Policy/ID Number: [Insurance ID Number, if applicable]

To Whom It May Concern,

I am writing to formally authorize the dispensing of the following compounded medication for the above-named patient under my clinical care for chronic pain management:

Medication Formula: [Insert Specific Ingredients and Strengths]

Dosage Form: [e.g., Topical Cream, Gel, Capsule]

Directions for Use: [Insert Sig/Instructions]

Quantity: [Insert Amount]

Refills: [Number of Refills]

Medical Necessity Statement:

The patient requires this specific compounded formulation because commercially available mass-produced alternatives have been trialed and failed, are contraindicated, or do not meet the specific delivery requirements for this patient's clinical condition. This customized medication is necessary for the effective management of the patient's pain levels and functional improvement.

Please process this prescription and dispense it to the patient as indicated. If there are any questions regarding this authorization or the formulation, please contact my office directly at [Prescriber Phone Number].

Sincerely,

[Prescriber Signature]

Prescriber Name: [Name and Title]

NPI Number: [NPI Number]

DEA Number: [DEA Number]

Clinic Name: [Clinic/Practice Name]