Date: [Date]

To: [Pharmacy Name]
Address: [Pharmacy Address]
Phone/Fax: [Pharmacy Contact Info]

RE: Dispensing Authorization for Compounded Hormone Replacement Therapy

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient Address: [Patient Address]

Dear Pharmacist,

This letter serves as formal authorization to dispense the following compounded hormone replacement medication(s) as prescribed for the above-named patient:

Prescription Details:

- **Medication/Formula:** [e.g., Bi-Est/Progesterone/Testosterone Compound]
- **Strength/Concentration:** [e.g., 2mg/50mg/1mg per ml]
- **Dosage Form:** [e.g., Topical Cream, Troche, Capsule]
- **Quantity:** [e.g., 30-day supply]
- **Directions for Use:** [e.g., Apply 1ml daily]
- **Refills Authorized:** [Number of Refills]

I confirm that I have evaluated the patient and determined that a customized compounded medication is medically necessary due to [Reason, e.g., specific dosage requirements not available commercially or allergy to inactive ingredients in commercial products].

Please dispense this medication in accordance with all state and federal regulations. Should you have any questions regarding this formulation or the patient's treatment plan, please contact my office directly.

Sincerely,

Physician Signature: _____

Physician Name: [Provider Full Name]
NPI Number: [NPI Number]
DEA Number: [DEA Number, if applicable]
Clinic Name: [Clinic Name]
Phone Number: [Phone Number]