

Date: [Insert Date]

To: [Pharmacy Name]

Pharmacist in Charge: [Pharmacist Name, if known]

Address: [Pharmacy Address]

RE: Allergen-Free Compounding Authorization

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Prescription Number: [RX Number, if applicable]

To Whom It May Concern,

I am writing to formally authorize and request that the prescribed medication for the above-mentioned patient be prepared as a customized compound. Due to severe allergies and sensitivities, this medication must be dispensed in an **allergen-free** format.

Please ensure the formulation is strictly free from the following excipients/fillers:

- [Insert Allergen, e.g., Gluten]
- [Insert Allergen, e.g., Corn/Maize]
- [Insert Allergen, e.g., Lactose/Dairy]
- [Insert Allergen, e.g., Artificial Dyes/Colors]
- [Insert Allergen, e.g., Soy]

I authorize the use of alternative hypoallergenic fillers (such as microcrystalline cellulose or ginger root powder) as deemed appropriate by the pharmacist to ensure the safety and efficacy of the medication.

If there are any concerns regarding the ingredients or if a substitute is unavailable, please contact me or the prescribing physician immediately before dispensing.

Sincerely,

[Signature of Patient or Legal Guardian]

Printed Name: [Name]

Phone Number: [Phone Number]

Prescribing Physician: [Physician Name]

Physician Phone: [Physician Phone Number]