Date: [Insert Date]

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

RE: Dispensing Authorization for Oncology Support Compound

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Medical Record Number: [MRN, if applicable]

To Whom It May Concern,

This letter serves as formal authorization for the dispensing of the following compounded medication(s) prescribed for the aforementioned patient as part of their oncology supportive care regimen:

Prescription Details:

- **Compounded Formulation:** [Insert Medication Name/Ingredients]
- **Strength/Concentration:** [Insert Strength]
- **Dosage Form:** [e.g., Topical Cream, Oral Suspension, Mouthwash]
- **Quantity:** [Insert Quantity]
- **Directions for Use:** [Insert Instructions]

Clinical Justification:
The patient is currently undergoing oncological treatment. This specific compounded formulation is medically necessary to manage [Side Effect/Condition, e.g., chemotherapy-induced stomatitis, radiation dermatitis] because commercially available manufactured products are either unavailable or clinically inappropriate for the patient's specific needs.

Prescriber Information:

Physician Name: [Prescriber Name]
NPI Number: [NPI Number]
Clinic/Hospital Name: [Oncology Center Name]
Phone Number: [Contact Number]

Please process this prescription immediately to avoid any delay in the patient's treatment plan. Should you require further clinical documentation or verification, please contact our office at [Phone Number].

Sincerely,

[Prescriber Signature]

[Prescriber Printed Name]
[Title/Department]