Date: [Insert Date]

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

RE: Dispensing Authorization for Compounded Medication

Patient Name: [Insert Patient Full Name]
Date of Birth: [Insert Date of Birth]
Patient ID/Chart #: [Insert ID Number]

To Whom It May Concern,

I am writing to formally authorize the compounding and dispensing of the following gastrointestinal medication for the above-named patient. Due to the specific clinical needs of the patient, a commercially available manufactured product is not suitable at this time.

Prescription Details:

- **Compounded Formulation:** [e.g., Omeprazole 2mg/mL Oral Suspension]
- **Indication:** [e.g., GERD, Gastritis, Eosinophilic Esophagitis]
- **Dosage/Instructions:** [Insert Instructions]
- **Quantity:** [Insert Amount]
- **Refills Authorized:** [Insert Number]

Clinical Justification for Compounding:
[Insert reason, e.g., Patient requires a liquid dosage form not available commercially / Patient has an allergy to a dye/filler in the commercial tablet / Specific dosage strength required].

Please dispense this medication as per the specifications above. If there are any questions regarding this formulation or the patient's therapy, please contact my office directly.

Sincerely,

Physician Signature: _____

Physician Name: [Insert Name]
NPI Number: [Insert NPI]
Clinic Name: [Insert Clinic Name]
Phone Number: [Insert Phone Number]