Date: [Date]

To: [Pharmacist Name/Pharmacy Name]
Address: [Pharmacy Address]
Phone: [Pharmacy Phone Number]

RE: Ophthalmologic Compound Prescription Dispensing Authorization

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

To Whom It May Concern,

I am writing to formally authorize the preparation and dispensing of the following compounded ophthalmic medication for the patient named above:

- **Medication Name/Formula:** [e.g., Atropine 0.01% Ophthalmic Solution]
- **Concentration/Strength:** [Specify Strength]
- **Quantity/Volume:** [Specify Amount]
- **Directions for Use:** [e.g., Instill 1 drop in each eye daily at bedtime]
- **Refills Authorized:** [Number of Refills]

I have determined that a commercially available product is not medically appropriate or available for this patient's specific clinical needs. Please ensure that this compound is prepared in a sterile environment in accordance with USP <797> standards for ophthalmic preparations.

Should you have any questions regarding this prescription or require further clinical justification, please contact my office at [Provider Phone Number].

Sincerely,

[Physician Signature]
Provider Name: [Provider Full Name]
NPI Number: [NPI Number]
Clinic Name: [Clinic/Hospital Name]
Address: [Clinic Address]