Date: [Insert Date]

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

RE: Controlled Substance Compound Prescription Dispensing Authorization

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Prescription Number (if applicable): [RX Number]

To Whom It May Concern,

I, Dr. [Physician Name], hereby authorize the dispensing of the following compounded controlled substance medication for the above-named patient:

Medication Formulation: [Insert Detailed Compound Formula/Ingredients]
Dosage Form: [e.g., Cream, Gel, Capsule]
Strength/Concentration: [Insert Strength]
Quantity: [Insert Quantity]
Directions for Use: [Insert Instructions]

I confirm that this compounded medication is medically necessary for the treatment of [Patient Diagnosis/Condition] and that a commercially available FDA-approved product is not suitable for this patient's specific clinical needs.

This authorization includes [Insert Number] refills. This prescription shall remain valid until [Insert Expiration Date] or until the total number of refills has been exhausted, whichever occurs first, in accordance with state and federal law.

If there are any questions regarding this authorization, please contact my office directly at [Physician Phone Number].

Sincerely,

Physician Signature: _____

Physician Name: [Print Name]
DEA Number: [Insert DEA Number]
NPI Number: [Insert NPI Number]
Clinic Name: [Insert Practice Name]
Address: [Clinic Address]