EXTENDED REFILL COMPOUND PRESCRIPTION DISPENSING AUTHORIZATION

Date: [Insert Date]

To: [Pharmacist Name/Pharmacy Name]
Pharmacy Address: [Insert Address]
Pharmacy Phone/Fax: [Insert Phone/Fax]

RE: Patient Authorization for Extended Dispensing

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Medication/Formula: [Insert Name of Compound]
Prescription Number (if known): [Insert Rx Number]

Dear Pharmacist,

I am the prescribing physician for the patient listed above. This letter serves as formal authorization to dispense an extended supply of the aforementioned compounded medication.

Due to [Reason: e.g., travel, insurance requirements, clinical stability], I authorize a dispensing quantity of a [Number]-day supply per fill, rather than the standard 30-day supply.

Authorization Details:

- **Quantity to Dispense:** [Insert Total Quantity/Volume]
- **Refills Authorized:** [Insert Number of Refills]
- **Effective Dates:** From [Start Date] to [End Date]

I confirm that I have reviewed the patient's medical history and the stability of the compound justifies this extended supply. Please contact my office if you have any questions regarding this authorization.

Sincerely,

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