Date: [Date]

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

Subject: Authorization for Replacement of Lost Prescription

To whom it may concern,

I am writing to formally authorize the replacement of a lost prescription for the following patient:

- **Patient Name:** [Full Name]
- **Date of Birth:** [MM/DD/YYYY]
- **Medication Name:** [Medication Name and Strength]
- **Original Prescription Date:** [Date of Original Script]
- **Reason for Replacement:** [Brief explanation, e.g., Lost during travel/Misplaced]

As the prescribing physician, I have verified the necessity of this medication and authorize a one-time replacement fill of [Number of Days] days or the remaining balance of the current refill.

Please contact my office at [Provider Phone Number] if you require further verification or have any questions regarding this authorization.

Sincerely,

[Physician Signature]
Physician Name: [Print Name]
NPI Number: [NPI Number]
Clinic/Hospital Name: [Facility Name]