Date: [Date]

To: [Pharmacist Name or Pharmacy Name]
Pharmacy Address: [Address, City, State, Zip Code]
Pharmacy Phone: [Phone Number]

RE: Prescription Replacement Authorization

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Prescription Number (if known): [Rx Number]

To Whom It May Concern,

I am writing to formally authorize a one-time emergency replacement for the medication listed below, as the patient has reported the original supply as lost or destroyed.

Medication Name: [Medication Name and Strength]
Dosage Instructions: [Instructions]
Quantity to Dispense: [Quantity]

I have reviewed the patient's records and determined that this replacement is medically necessary to ensure continuity of care. Please process this request and contact my office if there are any issues regarding insurance overrides or verification.

Thank you for your assistance.

Sincerely,

[Physician Signature]
Physician Name: [Physician Full Name]
DEA Number: [DEA Number]
NPI Number: [NPI Number]
Clinic Name: [Clinic/Hospital Name]
Phone Number: [Office Phone Number]