Date: [Date]

To: [Pharmacist Name/Staff Name]

From: [Physician/Provider Name]

Subject: Internal Approval for Lost Prescription Replacement

Patient Information:
Name: [Patient Full Name]
Date of Birth: [DOB]
Patient ID: [ID Number]

Medication Details:
Medication: [Drug Name and Dosage]
Original Issue Date: [Date]
Original Prescription Number: [RX Number, if known]

This letter serves as formal internal authorization to replace the prescription listed above. The patient has reported the medication as lost or destroyed. I have reviewed the patient's record and approved a one-time replacement fill.

Instructions:

- Issue a replacement for a [Number of Days] day supply.
- Update the patient's electronic medical record to reflect this replacement.
- Note the reason for replacement as: [Reason, e.g., lost/stolen/damaged].

Please contact me directly if there are any questions regarding this authorization.

Sincerely,

[Signature]
[Physician/Provider Name]
[DEA/NPI Number]