Date: [Date]

To: [Pharmacy Name / Insurance Provider Name]
Address: [Pharmacy/Provider Address]
Phone: [Phone Number]

Subject: Emergency One-Time Lost Prescription Replacement Authorization

Patient Information:
Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Member ID: [Insurance ID Number]
Group Number: [Group Number]

To whom it may concern,

I am writing to formally request and authorize an emergency one-time replacement for the following medication(s):

- **Medication Name:** [Drug Name and Strength]
- **Prescription Number (Rx#):** [Rx Number]
- **Original Prescriber:** [Doctor Name]

The original supply of this medication was lost due to [Reason: e.g., accidental disposal, travel loss, theft]. This medication is medically necessary for the patient's ongoing treatment, and a lapse in therapy poses a significant risk to their health.

I request that [Insurance Company Name] grant an "Override for Lost Medication" to allow for an immediate refill. I understand that this is a one-time emergency exception.

If you require further clinical justification or verification, please contact my office at [Doctor's Phone Number].

Sincerely,

[Doctor/Prescriber Signature]
[Doctor/Prescriber Printed Name]
[NPI Number]
[Clinic/Hospital Name]