[Patient Name]
[Patient Date of Birth]
[Patient Address]
[Phone Number]

[Date]

[Insurance Company or Pharmacy Name]
[Address]

RE: Dispense As Written (DAW) Medical Authorization

To Whom It May Concern,

I am writing to formally authorize and request that the following medication be dispensed exactly as prescribed by my physician:

Medication Name: [Brand Name Medication]
Dosage: [Strength/Frequency]
Prescribing Physician: [Doctor's Name]

My physician has designated this prescription as "Dispense As Written" (DAW) or "Brand Medically Necessary." This is due to [briefly state reason, e.g., clinical necessity, failure of generic alternatives, or specific allergies to inactive ingredients in generic versions].

I understand that choosing the brand-name version may result in a different co-pay or cost-sharing responsibility. I accept these terms to ensure the continuity and safety of my medical treatment as directed by my healthcare provider.

Please update my records to reflect this medical necessity for all future refills of this specific medication.

Sincerely,

[Signature]

[Printed Name]