Date: [Date]

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

RE: Prescription Substitution Denial Directive
Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Prescription Number(s): [Prescription Number or Medication Name]

Dear Pharmacist,

I am writing to provide a formal directive regarding the dispensing of my medication. I require the **Brand Name** version of the following medication: [Insert Medication Name].

I am specifically requesting that **no generic substitution** be made for this prescription. This directive is based on [Medical Necessity / Previous Adverse Reaction to Generics / Physician Recommendation].

Please ensure that my patient profile is updated to reflect a permanent "Dispense as Written" (DAW) or "Brand Medically Necessary" status for this specific treatment. I understand that choosing the brand-name version may result in a higher out-of-pocket cost or copayment, and I accept financial responsibility for this choice.

If there are any issues processing this request with my insurance provider or if a new prior authorization is required from my physician, please notify me immediately.

Thank you for your assistance in this matter.

Sincerely,

[Signature]
[Printed Name]
[Phone Number]

cc: [Physician Name]