

**Date:** [Date]

**To:** [Pharmacist Name/Pharmacy Name]

**Address:** [Pharmacy Address]

**Fax/Phone:** [Pharmacy Contact Information]

**RE: AUTHORIZATION FOR BRAND NAME ONLY**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient Date of Birth]

**Policy/Insurance ID:** [Insurance Number]

To Whom It May Concern,

I am writing to formally authorize and request that the following medication be dispensed exactly as prescribed, in its **Brand Name** form only:

**Medication Name:** [Brand Name Medication]

**Dosage:** [Dosage, e.g., 20mg]

**Instructions:** [Frequency/Instructions]

I am designating this prescription as "**Dispense as Written**" (**DAW**). Substitution with a generic equivalent is not authorized for this patient due to [Medical Necessity/Specific Sensitivity/Treatment Stability].

Please ensure that the Brand Name product is utilized for all future refills of this prescription unless otherwise notified by my office.

If there are any issues regarding insurance coverage or prior authorization requirements for the brand-name version, please contact my office immediately at [Phone Number].

Sincerely,

[Physician Signature]

**Physician Name:** [Name and Credentials]

**NPI Number:** [NPI Number]

**Clinic Name:** [Clinic/Practice Name]

**Phone:** [Phone Number]