[Physician Name]
[Clinic/Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [Pharmacy Name/Insurance Provider Name]
[Address]
[City, State, Zip Code]

RE: Dispense As Written (DAW) Directive for [Patient Name]
Date of Birth: [Patient DOB]
Member ID: [ID Number, if applicable]

To Whom It May Concern,

I am writing to formally direct that the medication(s) listed below be dispensed exactly as prescribed, with no generic substitution allowed (DAW-1).

Medication Name: [Brand Name Medication]
Dosage: [Dosage]
Frequency: [Frequency]

This directive is based on medical necessity. The patient has demonstrated [Reason: e.g., therapeutic failure on generic alternatives / specific allergy to excipients in generic versions / narrow therapeutic index requirements]. For the clinical safety and stability of the patient, the brand-name formulation is required.

Please ensure that this "Dispense As Written" instruction is noted in the patient's profile and applied to all refills for the duration of this prescription. If a prior authorization is required to honor this directive, please contact my office immediately at [Phone Number].

Thank you for your cooperation in the care of this patient.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[NPI Number]