

Date: [Date]

To: [Pharmacist Name / Pharmacy Name]

Pharmacy Address: [Pharmacy Address]

Pharmacy Phone/Fax: [Pharmacy Phone/Fax]

RE: Prescription Substitution Exemption (Dispense as Written)

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Medication Name: [Brand Name Medication]

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

To Whom It May Concern,

I am writing to formally request that the medication listed above be dispensed exactly as prescribed, using the specific brand name specified. This patient requires a "**Dispense as Written**" (DAW) or "**Brand Medically Necessary**" exemption from generic substitution.

The clinical justification for this exemption is as follows:

- [Reason 1: e.g., History of therapeutic failure with generic versions]
- [Reason 2: e.g., Documented allergy or sensitivity to specific excipients/binders in generic formulations]
- [Reason 3: e.g., Narrow Therapeutic Index (NTI) drug requirements]

Please ensure that all future refills for this specific prescription are filled with the brand-name product to maintain patient safety and treatment efficacy. If there are issues regarding insurance coverage or prior authorization requirements for this brand-name medication, please contact my office immediately.

Thank you for your cooperation in this matter.

Sincerely,

[Physician Signature]

Physician Name: [Physician Name, MD/DO]

NPI Number: [NPI Number]

Clinic Name: [Clinic/Hospital Name]

Phone Number: [Phone Number]