

[Date]

[Insurance Provider Name]  
[Prior Authorization Department]  
[Address]  
[City, State, Zip Code]

**RE: Dispense As Written (DAW) Justification**

**Patient Name:** [Patient First and Last Name]  
**Date of Birth:** [MM/DD/YYYY]  
**Policy Number:** [Insurance ID Number]  
**Group Number:** [Group Number]

To Whom It May Concern,

I am writing to provide a formal medical justification for the "Dispense As Written" (DAW) status for the following medication: **[Medication Name, Strength, and Dosage]**.

The patient has been under my care for [Diagnosis/Condition]. I am requesting that the brand-name version of this medication be authorized for the following clinical reasons:

- **Previous Treatment Failure:** The patient has previously attempted a trial of the generic version(s) of this medication from [Start Date] to [End Date]. During this trial, the patient experienced [Description of inadequate therapeutic response].
- **Adverse Reaction:** The patient experienced a documented allergic reaction or significant side effect specifically related to the inactive ingredients/excipients found in the generic formulation, including [Specific Side Effects].
- **Clinical Instability:** This patient requires a narrow therapeutic index medication. Switching to a generic alternative poses a significant risk of destabilizing the patient's current medical condition.

Based on the patient's clinical history and the necessity for consistent bioavailability, I have determined that the brand-name medication is medically necessary. Substituting this medication with a generic equivalent would likely result in [Anticipated Negative Outcome].

Please contact my office at [Phone Number] if you require additional documentation or clinical notes to process this request.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]  
[Clinic Name]

[NPI Number]  
[Phone Number]