

Date: [Date]

To: [Pharmacy Name/PBM Name]

Fax/Email: [Recipient Contact Information]

RE: AUTHORIZATION FOR ONGOING PRESCRIPTION TREATMENT

Claimant Name: [Patient Full Name]

Claim Number: [Claim Number]

Date of Injury: [Date of Injury]

Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

This letter serves as formal authorization for the ongoing prescription medication(s) required for the treatment of the work-related injury sustained by the claimant listed above.

The following medications have been approved as part of the established treatment plan:

- **Medication Name:** [Drug Name and Dosage] / **Refills:** [Number]
- **Medication Name:** [Drug Name and Dosage] / **Refills:** [Number]

Authorization Period: This authorization is valid from [Start Date] through [End Date/Until Further Notice].

Please process all billing directly through the Workers' Compensation carrier listed below:

Insurance Carrier: [Carrier Name]

Billing Address: [Billing Address]

Adjuster Name: [Adjuster Name]

Phone Number: [Adjuster Phone Number]

If there are any issues with processing these prescriptions or if further clinical documentation is required, please contact our office immediately.

Sincerely,

[Signature]

[Printed Name]

[Title/Organization]