

Date: [Date]

To: [Pharmacy Name / Provider Name]

Fax/Address: [Pharmacy Fax or Address]

RE: Workers' Compensation Prescription Authorization

Claimant Name: [Patient Name]

Date of Birth: [DOB]

Claim Number: [Claim Number]

Date of Injury: [Date of Injury]

Dear Pharmacist,

This letter serves as formal authorization for the following controlled substance(s) related to the above-referenced workers' compensation claim:

- **Medication Name:** [Medication Name and Strength]
- **Quantity Authorized:** [Total Quantity/Days Supply]
- **Prescribing Physician:** [Doctor Name]

The insurance carrier/employer, [Insurance Carrier Name], has reviewed the medical necessity for this medication and authorizes payment for this fill. Please process this prescription using the following billing information:

PBM/Processor: [PBM Name, e.g., Optum, Healthsystems]

BIN: [BIN Number]

PCN: [PCN Number]

Group ID: [Group ID]

This authorization is valid for this specific fill only. Any subsequent refills or changes in medication will require updated authorization.

If you have any questions or require further verification, please contact the adjuster, [Adjuster Name], at [Phone Number].

Sincerely,

[Your Name/Signature]

[Title]

[Company Name]