Date: [Date]

To: [Insurance Carrier/Adjuster Name]
Fax/Email: [Fax Number or Email Address]
Company: [Insurance Company Name]

RE: Prescription Refill Extension Authorization

Claimant Name: [Patient 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 is to formally request an immediate authorization for a prescription refill extension for the above-referenced claimant. The medication(s) listed below are necessary for the treatment of injuries sustained during the course of employment.

Medication Details:

- **Medication Name:** [Drug Name and Dosage]
- **Quantity:** [Number of Days Supply]
- **Prescribing Physician:** [Doctor Name]
- **Pharmacy Name:** [Pharmacy Name]
- **Pharmacy Phone:** [Pharmacy Phone Number]

The patient is currently out of medication or will be shortly. To ensure continuity of care and avoid a lapse in treatment, please provide authorization to the pharmacy listed above or provide a written approval via return fax.

If you require additional medical documentation or have any questions, please contact our office at [Your Phone Number].

Sincerely,

[Your Name/Signature]
[Your Title/Office Name]
[Phone Number]