[Your Name]
[Your Address]
[City, State, Zip Code]
[Email Address]
[Phone Number]
[Date]
[Pharmacy Name]
[Pharmacy Address]
[City, State, Zip Code]
Subject: Request for Repeat Prescription Authorization
Dear [Pharmacist's Name or Pharmacy Staff],
I am writing to request a repeat authorization for my prescription medication. Below are the details of the medication:
- **Patient Name:** [Your Name]
- **Date of Birth:** [Your DOB]
- **Prescribing Physician:** [Doctor's Name]
- **Medication Name:** [Medication Name]
- **Dosage:** [Dosage Information]
- **Prescription Number:** [Prescription Number]
- **Last Filled Date:** [Last Filled Date]
- **Number of Refills Requested:** [Number]

I have been using this medication to manage my [condition] and would appreciate your assistance in processing this authorization at your earliest convenience.
Please feel free to contact me if you need any additional information.
Thank you for your attention to this matter.
Sincerely,
[Your Name]