Medication Phase-Out Notification

Date: [Insert Date]

To: [Patient's Name]

[Patient's Address]

[City, State, ZIP Code]

Dear [Patient's Name],

We are writing to inform you about the phase-out of your current medication, [Medication Name]. After careful review and consideration of your treatment plan, it has been decided that discontinuing this medication may be in your best interest.

The decision to phase out [Medication Name] is based on [reason for phase-out, e.g., clinical guidelines, lack of efficacy, side effects, etc.]. We recommend transitioning to [Alternative Medication or Treatment] to ensure you continue to receive adequate care.

Please schedule an appointment with us to discuss your treatment plan moving forward and any concerns you may have regarding this change. Your health and well-being are our top priority, and we are here to support you through this transition.

Thank you for your understanding.

Sincerely,

[Your Name]
[Your Title]
[Your Contact Information]
[Practice/Clinic Name]