



### Medication Restriction Request Form

**Member Name:**  
**DOB:**  
**ID:**

This is a form to request medication(s) with safety concerns and/or potential for abuse to be restricted to one prescriber and/or pharmacy.

This member currently has a medication restriction in place for the following medication(s)/therapy class(es):

\_\_\_\_\_

\_\_\_\_\_

<b>Please indicate the following:</b>
<b>Are you willing to be the sole prescriber of these medications for the member?</b> a. Yes b. No
<b>In addition to yourself, are there any other prescribers who should have authority to prescribe restricted medication(s) for this member? If so, please provide prescriber name(s):</b>
<b>Indicate which medication(s)/class(es) should be restricted for this member:</b>
<b>Indicate if this member should be restricted to a particular pharmacy and if so, provide name and location of pharmacy:</b>

Please indicate the effective date for this restriction: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please fax completed form to the Pharmacy Services Department at: **(800) 366-4873**.

If you have any questions or concerns, please contact the Pharmacy Services Department Monday through Friday, 8:00 a.m. to 5:00 p.m. at (541) 330-2467 or toll-free at (855) 228-6229.