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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):

_____

_____

Please indicate the following:
Are you willing to be the sole prescriber of these medications for the member? a. Yes ☐ b. No ☐
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):
Indicate which medication(s)/class(es) should be restricted for this member:
Indicate if this member should be restricted to a particular pharmacy and if so, provide name and location of pharmacy:

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) 330-4999 or (888) 437-7728 toll-free.