**Medication Restriction Request Form**

**Member Name:**

**DOB:**

**ID:**

This is a form to request medications 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): **<therapy class(es)>.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Please indicate the following:** |
| **Are you willing to be the sole prescriber of these medications for the member?** * 1. Yes
	2. No
 |
| **In addition to yourself, are there any other prescribers who should have authority to prescribe restricted medications for this member? If so, please provide prescriber names:** |
|  |
|  |
| **Indicate which medications/therapy classes 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: **541-225-3665**.

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.