Medication restriction request

PacificSource Community Solutions

Use this form to request medications with safety concerns and/or potential for abuse be restricted to one prescriber and/or pharmacy.

Member name _____

DOB _____ Member ID _____

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

_____

_____

Please answer the following:

Are you willing to be the sole prescriber of these medications for the member? ◯ Yes ◯ 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:

_____

_____

Effective date for this restriction: _____

Signature

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**.