

P.O. Box 459089 Fort Lauderdale, FL 33345-9089

## **Pharmacy Lock-In Program Referral Form**

Fax the completed and signed form to 1-866-753-7452. For questions concerning the Lock-in program, call Provider Services at 1-844-477-8313 and ask to speak with a Pharmacy team member.

Recipient's Medicaid ID#	Date of Birth (MM/DD/YYYY)
Recipient's Full Name	
I am recommending that the above named recipient be placed in Sunshine Health's Pharmacy Lock-in Program. I understand that if the recipient meets criteria for this program, it will require this recipient to receive all their	
prescriptions from one pharmacy for a period of one year.	
The above named recipient has utilized Medicaid prescribed drug services that may be considered duplicative	
·	nd quantity for prescriptions filled. (Please provide details in
the space provided below.)	
The recipient would prefer to use the pharmacy below (if known):	
Pharmacy Name	
Pharmacy Medicaid Provider # NPI #	
Pharmacy Phone Number	Pharmacy Fax Number
REFERRAL SOURCE: Internal Pharmacy Physician	
REFERENCE: Internal Internal Internal Internal	
Name:	DOH License #:
Phone:	-
Signature:	Date:

1-844-477-8313 Provider Services