Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Recipient's Full Name

Pursuant to Florida Statue 409.912(45), I am recommending that the above named recipient be placed in the Recipient 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 and/or inappropriate with respect to the frequency and 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☐

NAME:_____ DOH LICENSE #: _____

PHONE: _____

Signature:_____ DATE: _____

When completed and signed by the referral source, please fax to Sunshine Health Pharmacy Department at (866) 351-7388. For questions concerning the Lock-in program, please call (866) 796-0530, ext. 41919.