sunshine health

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 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: _____