

**FORWARDHEALTH  
PHARMACY SERVICES LOCK-IN PROGRAM  
HMO REFERRAL FOR PHARMACY SERVICES LOCK-IN OF HMO MEMBER**

FOR HMO USE ONLY

The HMO lock-in coordinator is required to do the following:

1. Complete this form.
2. Complete the Pharmacy Services Lock-In Program HMO Designation of Prescriber for Restricted Medications Services form, F-00345.
3. Submit both forms to the Pharmacy Services Lock-In Program via fax at 800-881-5573, or mail at the following address:

Pharmacy Services Lock-in Program  
c/o Acentra  
PO Box 3570  
Auburn AL 36831-3570

Phone: 877-719-3123

4. Retain all supporting documentation in such manner that it can be made available upon request. **Do not submit supporting documentation with this form.**

Refer to the Medications Monitored by the Pharmacy Services Lock-In Program data table on the Pharmacy Resources page of the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/pharmacy/resources.htm.page#>.

**INSTRUCTIONS:** Type or print clearly.

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**SECTION I – MEMBER INFORMATION**

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Name – Member (Last, First, Middle Initial)

Member ID Number

Date of Birth

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**SECTION II – CRITERIA FOR REFERRAL FOR PHARMACY SERVICES LOCK-IN FOR RESTRICTED MEDICATIONS**

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Criteria (Check all that apply and that are documented. HMO lock-in coordinators must retain supporting documentation in their files.)

- There is evidence that the member intentionally provided incorrect information to a provider to obtain restricted medications (for example, incorrect ForwardHealth eligibility status, incorrect medical history).
- The member was convicted of a crime related to restricted medications within the past year (for example, forgery, theft, distribution).
- The member had **two or more** occurrences within a six-month period of violating a pain contract with the same prescriber or with different prescribers. A prescriber must agree to continue managing the member after the lock-in has been initiated.
- The member had any combination of **four or more** medical appointments, urgent care visits, or emergency room visits within a 14-day period at which they were seeking a restricted medication as the primary reason for the visit.
- The member required an emergency room visit or hospitalization in the last 90 days due to a suicide attempt, poisoning, or overdose from the use of restricted medication(s).

**Note: Referrals without an HMO Designation of Prescriber for Restricted Medications Services form will be returned as incomplete.**

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**SECTION III – REQUESTER INFORMATION**

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Name – HMO Lock-In Coordinator

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Name – HMO

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Phone Number – Requester

Fax Number – Requester

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**SECTION IV – CERTIFICATION AND SIGNATURE**

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By completing this referral and signing below, I certify the following:

- I have read and understand the guidelines for making this referral and have the supporting documentation necessary to validate the criteria selected on this form.
- I acknowledge that if the member appeals this lock-in decision, I or my representative will submit such documentation to the administrative law judge and testify at the appeal hearing in defense of this decision.
- I have included a completed Pharmacy Services Lock-In Program HMO Designation of Prescriber for Restricted Medications Services form with this referral.

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**SIGNATURE** – HMO Lock-In Coordinator

Date Signed

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