DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-11183 (02/2025)

STATE OF WISCONSIN
Wis. Stat. § 49.45(9)
Wis. Admin. Code § DHS 104.03

FORWARDHEALTH

PHARMACY SERVICES LOCK-IN PROGRAM
DESIGNATION OF ALTERNATE PRESCRIBER FOR RESTRICTED MEDICATIONS SERVICES

ForwardHealth requires certain information to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member ID number per Wis. Admin. Code § DHS 104.02(4).

Under Wis. Stat. § 49.45(4), personally identifiable information about applicants and members is confidential and is used for purposes directly related to program administration such as determining the eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is voluntary, and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form.

The designated Pharmacy Services Lock-In prescriber for restricted medications should complete this form and submit it to the Pharmacy Services Lock-In Program by fax at 800-881-5573 or by mail at the following address:

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

The prescriber being referred to should also be provided with a copy of this form. If the member is enrolled in an HMO, the HMO must be provided with a copy of this form. Providers may contact the Pharmacy Services Lock-In Program at 877-719-3123 with questions.

INSTRUCTIONS: Type or print clearly.

Name – Member (Last, First, Middle Initial)	
Member ID Number	Date of Birth – Member
Address – Member (Street, City, State, Zip Code)	
Name – Prescriber Being Referred (Last, First)	
National Provider Identifier (NPI) – Prescriber Being Referred	Phone Number – Prescriber Being Referred
Address – Prescriber Being Referred (Street, City, State, Zip+4 Code)	
Begin and End Date of Referral	

Reason for Referral and Type of Service to Be Rendered (Check One.)

❒ A) **In addition** to the restricted medications I prescribe, the member needs treatment for another diagnosis from this designated prescriber.

❒ B) **As an alternate** in my absence, the member may obtain restricted medications from this designated prescriber.

The member named on this form requires restricted medications services in addition to those I provide. I am referring the member to the designated prescriber indicated on this form.

Name – Designated Lock-In Prescriber (Print)	NPI – Designated Lock-In Prescriber
Phone Number – Designated Lock-In Prescriber	Fax Number – Designated Lock-In Prescriber
SIGNATURE – Designated Lock-In Prescriber	Date Signed

Reset Form