EXPRESS SCRIPTS
FEDERAL PHARMACY SERVICES®

MTF Rx Restriction Request Form (v1)

The preferred method to submit this form is via fax to the Express Scripts Prescription Monitoring Department at 866.579.4662. If you lack the ability to fax this form, call 866.333.1348 for alternative CAC encryption submission option.

****A Check Box Must Be Selected From Below When the Request Form Is Submitted****

New Request ☐ **Modify Existing Request** ☐ **Date:** _____ **Reinstatement** ☐ **Date:** _____

Restricted Beneficiary's Information

Is member assigned to a WTU:

Last Name: _____ First Name: _____ M.I.: ____

Sponsor SSN: _____ Birth Date: _____

Type of Lock (select ONE ONLY)

TYPE I LOCK

☐ Restrict **all meds** for a beneficiary to a specific pharmacy or list of pharmacies **and/or** providers or list of providers

Provider(s) Name & DEA/NPI: _____

CHCS Pharmacy or Retail Pharmacy Name and NPI, if available: _____

TYPE II LOCK

☐ Restrict **controlled meds** for a beneficiary to a specific pharmacy or list of pharmacies **and/or** providers or list of providers

Provider(s) Name & DEA/NPI: _____

CHCS Pharmacy or Retail Pharmacy Name and NPI, if available: _____

TYPE III LOCK

☐ Exclude controlled substances and/or specific noncontrolled substance(s) from a beneficiary at the **mail order or retail pharmacies**

☐ **II** ☐ **III** ☐ **IV** ☐ **V** **Other:** _____

Requestor POC Information

Reason for Request: Member has been notified of restriction ☐

Restricting MTF Site: _____ Effective Date: _____

Provider Phone Number: _____ Provider Email: _____

Provider Signature: _____ Date: _____

OR

Registered Nurse Phone Number: _____ Registered Nurse Email: _____

Registered Nurse Signature: _____ Date: _____

OR

MTF RPh Phone Number: _____ MTF RPh Email: _____

MTF RPh Signature: _____ Date: _____

Print Form