4665 Business Center Drive
Fairfield, California 94534

Date
CERTIFIED MAIL

Provider Name
Business
Business Street Address
City, State, Zip

RE: Member Restriction: Name
Birthdate:
CIN #:

Dear Dr. [Provider]:

Partnership HealthPlan of California (PHC) has identified the above member for potential *Restricted Member Status*. Restricted member status is assigned to a member when their drug profile has shown a high number of prescriptions for controlled medications from a provider, or a variety of providers and/or a variety of pharmacies.

In the interests of this member's safety and wellbeing, PHC is requesting your recommendations, comments and concerns for the implementation of restricted member status. **Please provide us with any comments regarding this member by completing the bottom portion of this letter and faxing it back to (707) 863-4330 *within 10 business days of the date of this letter.*** Your recommendations/comments will be reviewed by our medical director for final determination.

Please contact the PHC Pharmacy Department at (707) 863-4414 if you have any questions. You are also welcome to contact me directly at (707) 420-7663.

Sincerely,

_____
Stan Leung, Pharm. D.
Director, Clinical Pharmacy Programs

PHYSICIAN RECOMMENDATIONS:

☐ Prior Authorization required for all controlled medications.
☐ Prior Authorization required for specific medications: _____
☐ Restricted to one pharmacy for all medications
☐ Restricted to one pharmacy for all ***controlled*** medications
☐ NO Restrictions (Please provide reasons)

Comments: _____

_____

_____ _____
(Physician Signature) (Date)

<Department ID>