

**WASHTENAW HEALTH PLAN**  
**REQUEST FOR PRESCRIBING RESTRICTION**



**REQUESTING PHYSICIAN:**

|                     |
|---------------------|
| Name                |
| Direct Phone #      |
| Fax #:              |
| Physician Specialty |

**MEMBER INFORMATION:**

|   |  |
|---|--|
| Name  |  |
| WHP ID#   | Plan Type: <input type="checkbox"/> A <input type="checkbox"/> B |
| Date of Birth   |  |
| Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male |  |

\_\_\_\_\_  
*Name and title of person completing form (please print)*

If restriction is not requested by assigned PCP please complete the following:

Member's assigned PCP \_\_\_\_\_ Phone Number \_\_\_\_\_

**1. Please specify restriction requested below:**

|   |                        |       |
|---|------------------------|-------|
| <input type="checkbox"/> Pharmacy Restriction   | Name:                  | NABP# |
| <input type="checkbox"/> Prescriber Restriction | Name:                  | NPI # |
|   | Name:                  | NPI # |
|   | Name:                  | NPI # |
|   | Name:                  | NPI # |
|   | Name:                  | NPI # |
| <input type="checkbox"/> Medication Restriction | Member not to receive: |       |
|   | Member not to receive: |       |
| <input type="checkbox"/> Drug Class Restriction | Member not to receive: |       |
|   | Member not to receive: |       |

**2. Reason for restriction or additional information (attach additional documentation as applicable):**

**3. Check each statement to verify acknowledgment:**

- Completion of this request applies only to prescriptions processed through the HEALTH PLAN claims system. Note that the member could pay out of pocket to obtain a prescription.
- If the restriction applies to controlled substances, I will request a MAPS (Michigan Automated Prescription System) report at <https://sso.state.mi.us/> at least quarterly while the restriction is in place.
- If the restriction applied is a prescriber restriction, I will make arrangements for care of this member if I am out or town or on vacation and request the necessary temporary prior authorization for prescriptions from the WASHTENAW HEALTH PLAN.
- I will notify the member of restriction(s).
- I am the assigned PCP for this member or I have contacted the assigned PCP for verification.

**4D PHARMACY USE ONLY**

|                                  |                   |                        |
|----------------------------------|-------------------|------------------------|
| <input type="checkbox"/> Entered | Date: __/__/_____ | GCN: _____/_____/_____ |
| <input type="checkbox"/> Removed | Date: __/__/_____ |                        |

**Fax Requests to: WHP Nurse Coordinator, Fax: (734)544-6705**  
**For more information, phone: (734) 544-3034**

*WHP Nurse Coordinator COMMENTS:*