

3. Restrictions not requested by the assigned PCP will require that the assigned PCP be notified and concur before the edit will be processed.
4. Once completed the "Prescription Restriction" form will be sent by the UPHP Pharmacy Department to the pharmacy benefit manager. It should be noted the edit may take up to thirty days to be programmed and active.
5. If the restriction requested is regarding controlled substances, the assigned PCP or the requesting provider must request a MAPS (Michigan Automated Prescription System) report at least quarterly while the restriction is in place and evaluate it.
6. At such a time that it is desired to remove or change the prescription restriction, the requesting individual shall notify UPHP Pharmacy Department in writing. The assigned PCP will be contacted for concurrence, if the requesting individual is not the assigned PCP. Upon concurrence of the assigned PCP, the request will be submitted to the pharmacy benefit manager by UPHP Pharmacy. The removal of the prescription restriction programming may also take up to thirty days.
7. Every effort will be made to provide restriction or authorization of prescriptions during the implementation or removal of restrictions.

Attachments

UPPER PENINSULA HEALTH PLAN REQUEST FOR PRESCRIPTION RESTRICTIONS
form

Exception to this policy may be made with the approval of the
chief executive officer or an authorized designee.

/// END OF POLICY & PROCEDURE ///
UPPER PENINSULA HEALTH PLAN

UPPER PENINSULA HEALTH PLAN REQUEST FOR PRESCRIPTION RESTRICTION

REQUESTING INDIVIDUAL:

BENEFICIARY:

Name: (print) _____
First Last

Name: _____
First Last

Direct Phone #: (____) - ____ - ____

Member ID #: _____

Organization: _____

Date of Birth: __ - __ - ____ Sex: _____

Signature of Requesting Individual: _____

If restriction is not requested by the 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 #	NPI #
<input type="checkbox"/> Prescriber Restriction	Name:	DEA #	NPI #
	Name:	DEA #	NPI #
	Name:	DEA #	NPI #
	Name:	DEA #	NPI #
	Name:	DEA #	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 UPHP 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 www.michigan.gov/documents/cis_fhs_bhser_mapsform2_61987_7.pdf at least quarterly while the restriction is in place. I will forward a copy of the report to the UPHP Pharmacy Department at the address below.
- If the restriction applied is a prescriber restriction, I will arrange for care of this member if I am out of town or on vacation and request the necessary temporary prior authorization for prescriptions from UPHP.
- 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.

UPHP Approval _____ Date _____

4D PHARMACY USE ONLY			
<input type="checkbox"/> Entered	Date : __/__/____	GCN: ____/____/____	STC: _____
<input type="checkbox"/> Removed	Date : __/__/____		

Submit Implementation and Cancellation Requests to: Upper Peninsula Health Plan
 Attn: Pharmacy Dept.
 228 W. Washington St.
 Marquette, MI 49855
 Telephone: 888-904-7526 or 906-225-7500
 Fax: 906-225-7690