

**NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE  
PHARMACY LOCK-IN REFERRAL FORM**

This form is used for referring North Carolina Medicaid recipients with possible medication over utilization to the Recipient Management Lock-in Program to evaluate the need for possible lock-in to one prescriber and one pharmacy. Please fax this form along with any supporting documentation to 919-715-1255. For questions regarding the use of this form, call 919-855-4300. Please note this completed form contains Protected Health Information (PHI) and should be handled in accordance with HIPAA regulations.

**Referral Information**

Referral Source:

Medicaid Provider

CCNC Network Employee

Referral Name: \_\_\_\_\_

Referral Phone : \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Please include contact information for appeals support.

**Recipient Information**

Recipient Name: \_\_\_\_\_

Recipient Medicaid ID: \_\_\_\_\_

Recipient DOB: \_\_\_\_\_

**Reason for Referral**

Multiple Prescribers

Multiple prescriptions for narcotics

Multiple prescriptions for benzodiazepines

Other

Description of referral reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Attachments:  yes  no

Number of pages: \_\_\_\_\_