MCO Name MCO Logo

MCO Address

MCO Address

Date

«PHARM\_NAME»

«PHARM\_ADDR»

«PHARM\_CITY», «PHARM\_STATE» «PHARM\_ZIP»

RE: Placement into the South Carolina Medicaid Pharmacy Lock-In Program for:

 **Member Name: «FIRST» «LAST»**

 **MID#: «MID»**

 **DOB: «DOB»**

Dear Pharmacist:

The above Medicaid Member has been enrolled in the South Carolina Medicaid Pharmacy Lock-In Program for a more effective oversight of prescription drug therapy. They have been notified by letter of their enrollment in the Lock-In Program and they have selected **«PHARM\_NAME»** as their sole Lock-In Pharmacy for all of their Medicaid paid prescriptions for the next 24 months.

Beginning **INSERT DATE**, **«PHARM\_NAME»** will be the only pharmacy for which Medicaid will reimburse prescriptions filled for this member with the exception of mail order medications. They have been advised to transfer any outstanding refills to your pharmacy if they wish for their Medicaid benefits to cover the cost.

For EMERGENCIES: Overrides will be allowed:

* If a Member is on vacation,
* If the Lock In Pharmacy is out of the medication,
* If the Member has moved and not yet changed pharmacies.

With an override, the Member will only be given a 3-day (72 hour) supply of the medication. If, however, the Lock-In Pharmacy verifies the medication is not in stock, an override of up to a 30-day supply will be approved with a coordinating pharmacy of the Member’s choice that can supply the medication.

If there is a conflict with your pharmacy being the sole source of prescriptions for this member, please call XXXXX at XXX-XXX-XXXX within 10 days from receipt of this letter.

We appreciate your cooperation in this effort to improve services provided to the Medicaid beneficiaries of South Carolina.

At any time should you need to report possible fraudulent behavior, please call our Medicaid Fraud and Abuse Hotline at: XXX-XXX-XXXX.

 Thank you,

 XXXXXXXXXX

 XXXXXXXXXX