[*Instructions: Plans/Part D Sponsors may use this optional notice to confirm that the Plan/Part D Sponsor has processed a member request to stop receiving prescription drugs dispensed by a specific pharmacy or prescribed by a specific prescriber (sometimes referred to as a provider lock-out). The process may only be initiated by the member, when he/she indicates, through communication with the Part D sponsor via call, letter, or email), that he/she no longer wants to receive certain, or all medications from a specified provider (pharmacy and/or prescriber). Upon receipt of such a member request, the plan may implement member-specific claim edits to prevent coverage of medications, consistent with the member request. Prior to implementing the edit(s), the Plan/Part D Sponsor must clarify the exact edits that the beneficiary wants to put in place (i.e. a restriction on certain, or all drugs dispensed by the pharmacy and/or prescribed by the prescriber). The Plan/Part D sponsor may immediately process this restriction upon member request and may follow up with the letter below.*

*Plans/Part D Sponsors may make minor grammatical adjustments to this letter, as appropriate, and may insert any language about contractual obligations between the plan and the pharmacy that may reinforce this restriction.*]

**MEMBER REFUSAL REQUEST ON CERTAIN PRESCRIPTIONS**

<DATE>

<MEMBER NAME >

<ADDRESS>

<CITY, STATE, ZIP CODE>

Dear <MEMBER NAME>:

We understand that you no longer want to receive certain prescription medications that you have been receiving. This letter confirms that <PLAN NAME> has processed your request from <DATE>.

Starting on <DATE>, <PROVIDER NAME, NPI, ADDRESS> should no longer *[Insert one or both* <WRITE> <and/or> <FILL>*]* the following medications for you: *[Insert* PRESCRIPTION DRUG(S).*]* Your pharmacy will be unable to fill these medications and you should not receive them in the future.

Starting on <DATE>, <PLAN NAME> will stop covering the drug(s) listed above. **If you wish to start getting these medications from this provider again, please call <Customer/Member> Service at <phone number> (TTY/TDD users should call <TTY/TDD number>), we are available from <hours of operations>.**

We are sending the provider listed above a copy of this letter.

[*The plan may also provide instructions on reporting future suspicious or unauthorized services.*]

Sincerely,

<PLAN REPRESENTATIVE>

Cc: [*Insert* < provider name(s)>]

[*Pursuant to 42 CFR §423.2267, applicable disclaimers must be included in this letter.*]