Trillium Pharmacy Lock-In Referral Form

Trillium Community Health Plan
P.O. Box 11740
Eugene, Oregon 97440-3940

Recipient's OHP ID: _____ Date of Birth (MM/DD/YYYY): _____

Recipient's Full Name: _____

I am recommending that the above named recipient be placed in the Pharmacy Lock-In Program. I understand that if the recipient meets criteria for this program, it will require this recipient to receive their opioid prescriptions from one pharmacy and/or provider for a period of one year.

The above named recipient has utilized Oregon Health Plan prescribed drug services that may be considered duplicative and/or inappropriate with respect to the frequency and quantity for prescriptions filled. (Please provide details in the space provided below)

The recipient would prefer to use the pharmacy and/or provider below (if known). Fields marked with an asterisk (*) are required:

***Pharmacy Name**: _____ ***Pharmacy Phone Number:** _____

Pharmacy Fax Number: _____ **NPI #:** _____

Pharmacy DMAP #: _____

***Provider Name**: _____ ***Provider Phone Number:** _____

Provider Fax Number: _____ **NPI #:** _____

Provider DMAP #: _____

REFERRAL SOURCE: Internal ☐ Pharmacy ☐ Provider ☐

NAME:_____ LICENSE #:_____

PHONE: _____

SIGNATURE:_____DATE: _____

When completed and signed by the referral source, please fax to Trillium Pharmacy Department at <1-844-956-0157>. For questions concerning the Lock-In program, please call toll free 1-877-600-5472 or 1-541-485-2155.