Health Plan Logo
Health Plan
Address
Address

Lock-In Pharmacy Only Approval Letter

[Member Name]
[Member Address 1]
[Member Address 2]

Date: [date]

Dear [Member Name]:

Your Lock-In Pharmacy is approved. You should be able to get all of your medications from your Lock-In Pharmacy. Your Lock-In Pharmacy is listed below. Your Lock-In will begin on XX/XX/XXXX.

You should go to your Lock-In Pharmacy to receive all of your medications. If you need specialty medications, you may add a specialty pharmacy provider. The goal of your pharmacy Lock-In is to help you manage your medications in a healthier way. You may call the [Lock-In Contact] at the toll-free number below with any changes or questions about your Lock-In.

[Lock-In Pharmacy Name]
[Address Line 1]
[Address Line 2]
[Phone number]

Sincerely,

[Lock-In Contact]
[Health Plan Lock-In Contact]

(xxx) xxx-xxxx
Toll Free Phone Number

(xxx) xxx-xxxx
Fax Number