sunflower health plan
Phone: (877) 644-4623
Fax: (888) 453-4756

Adherence Packaging Request

I. MEMBER INFORMATION	II. PHARMACY INFORMATION
Patient Name:	Pharmacy Name:
ID Number:	NPI:
Date of Birth:	Address:
Address:	City, State, Zip:
City, State, Zip:	Phone:
Primary Phone:	Fax:
	Pharmacy Contact:

III. Adherence Packaging Checklist

Please complete the following reasons for adherence packaging.

☐ Member has one of the following diagnosis:

- ☐ HIV
- ☐ Seizures
- ☐ Visual Impairment
- Severe and Persistent Mental Illness: ☐ Schizophrenia ☐ Bipolar Disorder ☐ Major Depressive Disorder (MDD): ICD-10 F32 or F33
- Cognitive Disorder: ☐ Alzheimer's ☐ Dementia ☐ Traumatic Brain Injury (TBI) ☐ Intellectual or Developmental Disorder (IDD)

☐ Member is receiving anti-rejection therapy for organ transplant

☐ Member resides in a residential program (Group Home, Assisted Living Facility, Nursing Home, ICF/MR, PRTF)

☐ Member is enrolled in the Lock-In Program

☐ Member is enrolled in Pain Management Program/Pain Contract where adherence packaging is required

☐ Adherence packaging is preventing a need for Home Health Services

☐ Prescriber requires member to receive adherence packaging (Prescriber Name: _____Phone: _____)

☐ Pharmacist-determined Medical Necessity for adherence packaging (*please state reason below*):

Reason:_____

_____

By signing below, I hereby acknowledge that all information is true and correct.

Pharmacist's Name: _____ Pharmacist's Signature: _____ Date____/_____/____

Your attestation may be audited to request proof of the exception reason. Dispensing fees paid in excess of 90-day supplies may be recouped if appropriate proof of member meeting criteria is not provided upon request.