[Date]

[Member Name]
[Member Address]
[City, State, Zip Code]

RE: Notice of Multiple Pharmacy Use Violation - Final Follow-Up

Dear [Member Name],

We are writing to follow up on our previous notice dated [Date of Original Letter] regarding your use of multiple pharmacies to fill controlled substance prescriptions. Our records indicate that you have continued to fill prescriptions at various pharmacy locations, which is a violation of your [Insurance Plan Name] policy guidelines.

For your safety and to ensure proper coordination of care, our policy requires members identified with high-risk medication patterns to use one single designated pharmacy for all prescriptions.

Required Action:
As of [Effective Date], you must fill all future prescriptions at the pharmacy listed below:

Designated Pharmacy: [Pharmacy Name]
Address: [Pharmacy Address]
Phone Number: [Pharmacy Phone Number]

If you attempt to fill a prescription at any other pharmacy after the date listed above, the claim will be denied at the point of sale. If you wish to request a change to your designated pharmacy due to a relocation or pharmacy closure, you must contact us at least [Number] days in advance.

If you believe this information is in error, or if you wish to appeal this decision, please contact our Member Services Department at [Phone Number] (TTY: [Number]) between the hours of [Hours of Operation].

Sincerely,

[Name/Department]
[Insurance Company/Pharmacy Benefit Manager Name]