CVS/caremark™

Date

PRESCRIBER SERVICES
CLINICAL INFORMATION

Prescriber Name
Street Address
City, State Zip

Case No: DUR-SM: xxxxxxxxx-x

Dear Prescriber Name,

Re: Plan Member Name **Birthdate: xx/xx/xxxx**

CVS Caremark is conducting a review of patient claims. This is to ensure that benefits are being administered according to the terms of coverage outlined in the patient's CVS Caremark plan. The patient listed above was identified through a claims review† as having unusual medication utilization patterns which may indicate possible drug over-utilization and may place them at risk for drug-induced adverse events. An initial letter may have been sent to you over one month ago. This letter provides you with medication claim information and is being sent to all prescribers who have written prescriptions for this patient.

We are enclosing a copy of your patient's medication profile, which according to our records, lists medications that were dispensed under the above patient's beneficiary ID number during a recent nine-month period. The targeted medication includes drugs with high abuse potential.

Based on this information, please verify and/or consider the following on the attached response form:

(1) The identified patient is your patient
(2) The identified medications were prescribed by you
(3) The identified medications are medically necessary due to a specific diagnosis (please provide diagnosis)
(4) Re-evaluation of current drug therapy

Your cooperation will greatly assist us in our ongoing review of this patient's drug utilization as we partner with you to ensure safe and appropriate management of this patient's disease state. **Please respond via FAX** at (866) 443-9163 within 7-10 days. We hope this information is helpful and thank you for your assistance.

Clinical Services
CVS Caremark

†Patient identified through provided medical and pharmacy claims data.
CVS Caremark adheres to all privacy standards and our employees are trained regarding the appropriate way to handle private health information. We endeavor to provide you with accurate information. If you receive information you believe to be incorrect, or information about a patient not currently under your care, please let us know; we ask that you also destroy the information in a confidential manner. The use of Protected Health Information in this publication is permitted under HIPAA.

NALOXONE is available for patients on high dose pain medications or otherwise at risk of opioid overdose.

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PRESCRIBER SERVICES
CLINICAL INFORMATION

Prescription Claim Details

xxxxxxxxx-x

PATIENT INFORMATION

Name:

DOB:

Gender: **Carrier Name:**

CLAIM DETAILS

Fill Date	Drug Name & Strength	Dosage Form	Qty	D/S	Refill	Rx #	Prescriber Name	NABP (NPI)

Some sensitive medications with low risk for abuse may have been omitted from the enclosed profile.

Prescription Claim Details

xxxxxxxxx-x

PATIENT INFORMATION

Name:

DOB:

Gender: **Carrier Name:**

PROVIDER INFORMATION

Name	Specialty	Address	Phone	Fax

PHARMACY INFORMATION

NABP (NPI)	Name	Address	Phone

Some sensitive medications with low risk for abuse may have been omitted from the enclosed profile.

This page contains the names of prescription brand-name drugs that are trademarks or registered trademarks of pharmaceutical manufacturers that are not affiliated with CVS Caremark.

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PRESCRIBER SERVICES
CLINICAL INFORMATION

Controlled Substances Review
Prescriber Response Form

Attn: Date:

Patient Name: **DOB:**

Prescriber Name:

DIAGNOSIS and/or ICD Codes	_____ _____ _____ _____
Patient Profile Overview	Yes ○ No ○ N/A ○ Do you have concerns with the overall utilization or medication profile of this patient? (medications, quantities, doses, frequency of fills, number of prescribers/pharmacies, etc.) Yes ○ No ○ N/A ○ Were you aware of the controlled substances from other providers? (if applicable)
Action Plan: **(select all that apply)**	○ Re-evaluate therapy and/or discuss concerns with patient at next appointment. ○ Discuss medication regimen with the other provider(s) and coordinate therapy. (if applicable) ○ Refer patient to specialist ○ Other_____
Relationship with Patient: **(select all that apply)**	○ Primary Care Provider ○ Specialist (Please provide your specialty):_____ ○ Emergency Room/Urgent Care setting:_____ ○ Have no record of this patient ○ Other:_____

Additional information/comments: _____

_____

_____

_____ _____

Signature Date

Fax Toll Free 1-866-443-9163

For any questions regarding prescriptions filled under your name, please contact the dispensing pharmacy directly.

R215732184-1

Case Number: **DUR-SM: xxxxxxxxx - x** **CBFHDCBJEB** Intervention Date: 11/07/2016