



Date

**PRESCRIBER SERVICES
CLINICAL INFORMATION**

Prescriber Name
Street Name
City, State Zip

Case No: DUR-SM: xxxxxxxx-x

Dear Prescriber Name,

Re: Member Name

Birthdate:

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. 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.

Prescription Claim Details

XXXXXXXX-X

PATIENT INFORMATION

Name: _____

DOB: _____

Gender: _____

Carrier Name: _____

CLAIM DETAILS

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

<u>Name</u>	<u>Specialty</u>	<u>Address</u>	<u>Phone</u>	<u>Fax</u>
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PHARMACY INFORMATION

<u>NABP (NPI)</u>	<u>Name</u>	<u>Address</u>	<u>Phone</u>
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**Controlled Substances Review
Prescriber Response Form**

Attn: _____

Date: _____

Patient Name: _____

DOB: _____

Prescriber Name: _____

DIAGNOSIS and/or ICD Codes	<hr/> <hr/> <hr/> <hr/>			
Patient Profile Overview	Yes <input type="radio"/>	No <input type="radio"/>	N/A <input type="radio"/>	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 <input type="radio"/>	No <input type="radio"/>	N/A <input type="radio"/>	Were you aware of the controlled substances from other providers? (if applicable)
Action Plan: (select all that apply)	<input type="radio"/> Re-evaluate therapy and/or discuss concerns with patient at next appointment. <input type="radio"/> Discuss medication regimen with the other provider(s) and coordinate therapy. (if applicable) <input type="radio"/> Refer patient to specialist <input type="radio"/> Other: _____			
Relationship with Patient: (select all that apply)	<input type="radio"/> Primary Care Provider <input type="radio"/> Specialist (Please provide your specialty): _____ <input type="radio"/> Emergency Room/Urgent Care setting: _____ <input type="radio"/> Have no record of this patient <input type="radio"/> 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.



Case Number: **DUR-SM:** xxxxxxxxxx - x

CBFHDCBJEB

Intervention Date: 11/07/2016

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. 106-34929a 072815