

Date

PRESCRIBER SERVICES CLINICAL INFORMATION

Prescriber Name Street Address City, State Zip

Case No: DUR-SM: xxxxxxxxxx-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:

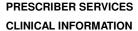
- (1) The identified patient is your patient
- (2) The identified medications were prescribed by you
- (3) The identified medications are medically necessary due to a specific diagnosis (please provide diagnosis)
- (4) Re-evaluation of current drug therapy

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.



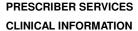


Prescription Claim Details

xxxxxxxxx-x

PATIENT I	NFORMATION					
Name	:					
DOB	:					
Gender	: Carrier Name:					
CLAIM DE	AILS					
Fill Date	Drug Name & Strength	Dosage Form	Qty	D/S Refill Rx #	Prescriber Name	NABP (NPI)

Report Date: 11/07/2016





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	_	

Report Date: 11/07/2016



Attn:

PRESCRIBER SERVICES
CLINICAL INFORMATION

Controlled Substances Review Prescriber Response Form

Date:

Patient Name:		DOB:			
Prescriber I DIAGNOSIS and/or ICD Codes	Name:				
Patient Profile Overview	Yes O Yes	0 0	profile of this patient? frequency of fills, num Were you aware of the	with the overall utilization or medication (medications, quantities, doses, aber of prescribers/pharmacies, etc.) controlled substances from other ale)	
Action Plan: (select all that apply)	00 00	 Discuss medication regimen with the other provider(s) and coordinate therapy. (if applicable) Refer patient to specialist 			
Relationship with Patient: (select all that apply)	O Primary Care Provider O Specialist (Please provide your specialty): O Emergency Room/Urgent Care setting: O Have no record of this patient O Other:				
Additional i	nform	ation/commen	nts:		
_			Signature	Date	

Fax Toll Free 1-866-443-9163

For any questions regarding prescriptions filled under your name, please contact the dispensing pharmacy directly. * R 2 1 5 7 3 2 1 8 4 - 1 *

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

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

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