<LOGO>

<DATE>

<Pharmacy Name>

<ADDRESS>

<CITY, STATE ZIP>

RE: <PATIENT NAME> DOB: <DOB>

Case Number: xxxxxxxxxx

Dear Pharmacist in Charge:

<Plan Name> is sending you this letter to request your assistance. We have important clinical information about this patient’s utilization of prescription <opioids> or <benzodiazepines> or

<opioids and benzodiazepines>. <Plan Name> is the Medicare prescription drug benefit plan for

<Patient Name>. Our Drug Management Program reviews utilization by our plan enrollees that involve multiple prescribers and/or pharmacies, and flags for case management utilization that is potentially unsafe.

<Plan name> is sending you this letter because we are limiting this patient’s prescription benefits to your pharmacy. He or she will only be able to obtain <opioid> or <benzodiazepines> or

<opioid and benzodiazepines> from this pharmacy. We are taking this action to help to ensure that this patient’s prescriptions are being managed appropriately.

We have selected your pharmacy because it is close to the patient’s home, with convenient hours and a variety of services. Thank you for partnering with us to ensure the appropriate use of prescription drugs.

We thank you for your assistance in addressing this matter and urge you to be responsive. If we are unable to establish fax communication with your pharmacy, we will be reaching out to you via telephone to confirm.

Please verify the pharmacy information listed below and send your approval in writing to this toll- free fax number: 1-866-643-5131.

<Pharmacy Name>

<ADDRESS>

<CITY, STATE ZIP>

CHECK BOX AND SIGN IF APPROVED

Sincerely,

Clinical Services

<Plan Name>