<LOGO>

<DATE>

<PRESCRIBER NAME>

<ADDRESS>

<CITY, STATE ZIP>

Case Number: DUR-ES-xxxxxxxx

RE: <MEMBER NAME> DOB: <DOB>

Dear Dr. <PRESCRIBER NAME>:

<Plan Name> is sending you this letter to request your assistance. We have important clinical information about your patient’s utilization of prescription <opioids> or <benzodiazepines> or <opioids and benzodiazepines> for use in your treatment of this patient. <Plan Name> is the Medicare prescription drug benefit plan for your patient, <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.

We would appreciate your review of the total prescription drug utilization of your patient, <Name of Patient>, your opinion whether your patient is at risk for prescription drug abuse or misuse, and information about any relevant treatment factors, such as whether your patient is being treated for active cancer-related pain or is receiving hospice, palliative, or end-of-life care services. If so, we would like to work with you <and the other prescribers of these drugs> to determine how your patient’s utilization of these drugs should be more closely managed.

We have attached information about the <opioid> or <benzodiazepine> or <opioid and benzodiazepine> medications prescribed for <Patient Name> of which we are aware, such as the prescribers, dosage(s) (quantities and days’ supply) prescribed, dispensing dates and time period we are reviewing. Your input is imperative for determining whether the current utilization for <opioids> or <benzodiazepines> or <opioids and benzodiazepines> is appropriate, medically necessary, and safe for <Patient Name>. We will be calling you, <and the other prescribers of these drugs>, to discuss this case.

When multiple prescribers are involved, the goal of our Drug Management Program is to achieve a consensus among all prescribers as to the appropriate, medically necessary, and safe dosage for <Patient Name>, and if there is no consensus, to facilitate one.

We thank you for your assistance in addressing this matter and urge you to be responsive. If we are unable to establish through communication with the prescriber(s) of these drugs that the current dosage of <opioid> or <benzodiazepine> or <opioid and benzodiazepine> medication(s) are appropriate, medically necessary, and safe for <Patient Name>, we may have to place a limitation on <Patient Name’s> access to coverage of some or all of these medications. In addition, a limitation may assist you in managing <Patient’s Name> safe use of <opioids> or <benzodiazepines> or <opioids and benzodiazepines>. Therefore, your input is imperative.

Sincerely,

Clinical Services

<Plan Name>