SilverScript®

P.O. Box 52431, Phoenix, AZ 85072-2431

January 10, 2017

30789
SUMANA DHARANIKOTA KETHA
2925 SKYWAY CIR N STE 300
IRVING, TX 75038-3510

Dear Dr. SUMANA DHARANIKOTA KETHA:

PRESCRIBER COPY - Your patient recently received this notice. This copy is provided for your information and follow up.

**YOUR DRUG IS NOT ON OUR LIST OF COVERED DRUGS (FORMULARY)
OR IS SUBJECT TO CERTAIN LIMITS**

Dear CARRIE HEROD: Member DOB: 12/01/1928

We want to tell you that SilverScript Choice (PDP) has provided you with a temporary supply of the following prescription: LIDOCAINE OIN 5%.

This drug is either not included on our list of covered drugs (called our formulary), or it's included on the formulary but subject to certain limits, as described in more detail later in this letter. SilverScript Choice (PDP) is required to provide you with a temporary supply of this drug, as follows:

In the outpatient setting, we're required to provide a maximum of 30-day supply of medication. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum 30-day supply of medication.

It's important to understand that this is a temporary supply of this drug. Well before you run out of this drug, you should speak to SilverScript Choice (PDP) and/or the prescriber about:

- changing the drug to another drug that is on our formulary; or
- requesting approval for the drug by demonstrating that you meet our criteria for coverage; or
- requesting an exception from our criteria for coverage.

When you request approval for coverage or an exception from coverage criteria, these are called coverage determinations. Don't assume that any coverage determination, including any exception, you have requested or appealed has been approved just because you receive more fills of a drug. If we approve coverage, then we'll send you another written notice.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at 1-866-235-5660. TTY users should call 711. Live representatives are available 24 hours a day, 7 days a week. You can ask us for a coverage determination at any time. **Instructions on how to change your current prescription, how to ask for a coverage determination, including an exception, and how to appeal a denial if you disagree with our coverage determination are discussed at the end of this letter.**

The following is a specific explanation of why your drug is not covered or is limited.

Name of Drug: LIDOCAINE OIN 5%

Date Filled: 01/07/2017
Reason for Notification: This drug is on our formulary, but requires prior authorization. Unless you obtain prior authorization from us by showing us that you meet certain requirements, or we approve your request for an exception to the prior authorization requirements, we will not continue to pay for this drug after you have received the maximum 30 days' temporary supply that we are required to cover.

How do I change my prescription?
If your drug is not on our formulary, or is on our formulary, but we have placed a limit on it, then you can ask us what other drug used to treat your medical condition is on our formulary, ask us to approve coverage by showing that you meet our criteria, or ask us for an exception. We encourage you to ask your prescriber if this other drug that we cover is an option for you. You have the right to request an exception from us to cover your drug that was originally prescribed. If you ask for an exception, your prescriber will need to provide us with a statement explaining why a prior authorization, quantity limit, or other limit we have placed on your drug is not medically appropriate for you.

How do I request a coverage determination, including an exception?
You or your prescriber may contact us to request a coverage determination, including an exception. The toll-free phone number is 1-866-235-5660 (TTY users should call 711), or you may fax to 1-855-633-7673, or you may write to us at: SilverScript® Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department, P.O. Box 52000, MC 109, Phoenix, AZ 85072-2000. We are available 24 hours a day, 7 days a week.

If you are requesting coverage of a drug that is not on our formulary, or an exception to a coverage rule, your prescriber must provide a statement supporting your request. It may be helpful to bring this notice with you to the prescriber or send a copy to his or her office. If the exception request involves a drug that is not on our formulary, the prescriber's statement must indicate that the requested drug is medically necessary for treating your condition because all of the drugs on our formulary would be less effective as the requested drug or would have adverse effects for you. If the exception request involves a prior authorization or other coverage rule we have placed on a drug that is on our formulary, the prescriber's statement must indicate that the coverage rule wouldn't be appropriate for you given your condition or would have adverse effects for you.

We must notify you of our decision no later than 24 hours, if the request has been expedited, or no later than 72 hours, if the request is a standard request, from when we receive your request. For exceptions, the timeframe begins when we obtain your prescriber's statement. Your request will be expedited if we determine, or your prescriber tells us, that your life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard decision.

What if my request for coverage is denied?
If your request for coverage is denied, you have the right to appeal by asking for a review of the prior decision, which is called a redetermination. You must request this appeal within 60 calendar days from the date of our written decision on your coverage determination request. We accept standard and expedited requests by telephone and in writing. Contact us at: SilverScript Insurance Company Prescription Drug Plans Coverage Decisions and Appeals Department, P.O. Box 52000, MC 109, Phoenix, AZ 85072-2000, phone: 1-866-235-5660, fax: 1-855-633-7673, TTY: 711.

If you need assistance in requesting a coverage determination, including an exception, or if you want more information about when we will cover a temporary supply of a drug, contact us at 1-866-235-5660, 24 hours a day, 7 days a week. TTY users should call 711. Live representatives are available 24 hours a day, 7 days a week. You can ask us for a coverage determination at any time. You can also visit our website at www.silverscript.com.

Sincerely,

SilverScript Choice (PDP)

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments and restrictions may apply. Benefits, premium and/or copayments/coinsurance may change on January 1 of each year.

The formulary may change at any time. You will receive notice when necessary.

Beneficiaries must use network pharmacies to access their prescription drug benefit.

SilverScript is a Prescription Drug Plan with a Medicare contract offered by SilverScript Insurance Company. Enrollment in SilverScript depends on contract renewal.

2017 SilverScript
Commonly Prescribed Non-Formulary Drugs and Formulary Alternatives
(Brand-name drugs* are capitalized and generic drugs are listed in lower-case italics)

Drug Name	Formulary Alternatives
ABILIFY DISC TAB 10MG	*aripiprazole odt tab*
acyclovir oin 5%	*acyclovir tab/cap, valacyclovir tab, famiciclovir tab*
ASTEPRO SPR 0.15%	*azelastine spr*
BIDIL TAB	*hydralazine with isosorbide dinitrate tab 20mg*
BINOSTO TAB 70MG	*alendronate tab*
calcipotrien oin 0.005%	*calcipotriene cream, calcipotriene soln*, TAZORAC CREAM
CALCITRENE OIN 0.005%	*calcipotriene cream, calcipotriene soln*, TAZORAC CREAM
CIMZIA KIT	HUMIRA, REMICADE
CIMZIA KIT STARTER	HUMIRA, REMICADE
CIMZIA PREFL KIT 200MG/ML	HUMIRA, REMICADE
clobetasol cre 0.05%	*augmented betamethasone diproprionate 0.05% cre, halobetasol 0.05% cre*
clobetasol e cre 0.05%	*augmented betamethasone diproprionate 0.05% cre, halobetasol 0.05% cre, fluocinonide gel*
clobetasol gel 0.05%	*augmented betamethasone diproprionate 0.05% gel, fluocinonide gel*
clobetasol oin 0.05%	*augmented betamethasone diproprionate 0.05% oin, halobetasol 0.05% oin*
clobetasol sol 0.05%	*fluocinonide sol 0.05%*
CORMAX SCALP SOL 0.05%	*fluocinonide sol 0.05%*
ELIDEL CRE 1%	*tacrolimus oin*
FAZACLO TAB 150 ODT	*clozapine tab odt*
FAZACLO TAB 200 ODT	*clozapine tab odt*
fenofibric cap 135mg dr	*fenofibrate tab 48mg, 54mg, 145mg, 160mg, fenofibrate cap micronized 67mg, 134mg, 200mg*
fenofibric cap 45mg dr	*fenofibrate tab 48mg, 54mg, 145mg, 160mg, fenofibrate cap micronized 67mg, 134mg, 200mg*
fluocinonide oin 0.05%	*fluticasone oin 0.005%, betameth val oin 0.1%, mometasone oin 0.1%, betamethasone diproprionate 0.05% oint*
ibandronate tab 150mg	*alendronate tab*
levonorgestrel tab 0.75mg	*levonorgestrel tab 1.5mg*, ELLA TAB 30mg
MODERIBA PAK 1000/DAY	*ribavirin cap, tab 200mg*
MODERIBA PAK 1200/DAY	*ribavirin cap, tab 200mg*
MODERIBA PAK 800/DAY	*ribavirin cap, tab 200mg*
MODERIBA PAK 600/DAY	*ribavirin cap, tab 200mg*
NUCYNTA ER TAB	*morphine ext-rel tab*, EMBEDA, OXYCONTIN, OPANA ER, HYSINGLA ER
olopatadine spr 0.6%	*azelastine spr 0.1%, azelastine spr 0.15%*

* This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.

Drug Name	Formulary Alternatives
PEG-INTRON KIT	PEGASYS INJ
PERFOROMIST NEB 20MCG	SEREVENT DIS AER 50MCG
PRUDOXIN CRE 5%	*doxepin hcl cre 5%*
RIBAPAK PAK 1000/DAY	*ribavirin cap, tab 200mg*
RIBAPAK PAK 1200/DAY	*ribavirin cap, tab 200mg*
RIBAPAK PAK 600/DAY	*ribavirin cap, tab 200mg*
RIBAPAK PAK 800/DAY	*ribavirin cap, tab 200mg*
ROZEREM TAB 8MG	SILENOR, *temazepam* (PA applies if 65 years and older after a 90-day supply in a calendar year), ZOLPIDEM (PA applies if 70 years and older after a 90-day supply in a calendar year)
SURMONTIL CAP 100MG	*trimipramine cap*
SURMONTIL CAP 25MG	*trimipramine cap*
SURMONTIL CAP 50MG	*trimipramine cap*
TANZEUM INJ 30MG	BYDUREON INJ, VICTOZA INJ, BYETTA INJ, TRULICITY INJ
TANZEUM INJ 50MG	BYDUREON INJ, VICTOZA INJ, BYETTA INJ, TRULICITY INJ
TEKTURNA HCT TAB	*lisinopril-hctz, enalapril-hctz, losartan-hctz, irbesartan-hctz, valsartan-hctz*
TEKTURNA TAB	*lisinopril, enalapril, losartan, irbesartan, valsartan*
TIKOSYN CAP	*dofetilide cap*
UCERIS TAB 9MG	*sulfasalazine tab, sulfasalazine ec tab, balsalazide cap,* ASACOL HD TAB, DELZICOL CAP, APRISO CAP
ZYVOX TAB 600MG	*linezolid tab*