Model Part D Drug Management Program Prescriber Inquiry Letter

Instructions: This model could be used to notify prescribers of frequently abused drugs that their patient's utilization pattern of frequently abused drug(s) and/or their history of opioid-related overdose is potentially unsafe and has prompted a case management review under the plan's Drug Management Program. Plans may use all or part of the language in this model, modify the language, or create their own language.

<DATE>
<PRESCRIBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

RE: <BENEFICIARY NAME> <CASE IDENTIFIER>

Dear [PRESCRIBER NAME]:

<Plan Name> is sending you this letter to request your assistance and response. We are the Medicare prescription drug benefit plan for your patient, <Beneficiary Name>. We have important information, of which you may or may not be aware, about their utilization of prescription <<opioids> or <benzodiazepines> or <opioids and benzodiazepines> <and history of opioid-related overdose>>. The information may assist you in treating this patient. Under our Drug Management Program, we review opioid utilization by plan enrollees that involves multiple prescribers and/or pharmacies, and/or a history of opioid-related overdose, and identifies potentially unsafe utilization for case management.

<We have <listed below> <attached> information about the <opioid> <and benzodiazepine> medications prescribed for <Beneficiary Name> of which we are aware, including the prescriber(s), dosage(s) (quantities and days' supply) prescribed, dispensing dates and time period we are reviewing.> <Based on a review of administrative claims, it appears that they have a history of opioid-related overdose.>

We would appreciate your review of the total prescription drug utilization <and overdose history> of this patient, and your opinion whether they are at-risk for prescription drug misuse or abuse. We are also interested in learning other relevant information from you, including whether they are being treated for cancer-related pain, receiving hospice, palliative, or end-of-life care services, or have sickle cell disease. If they are at-risk, we would like to work with you {and the other prescribers of these drugs} to determine how their utilization of these drugs should be more closely managed.

When multiple prescribers are involved, the goal of our Drug Management Program is to obtain input from all prescribers regarding the appropriate, medically necessary, and safe utilization for the patient, and determine whether a coverage limitation might assist you in managing their safe use of <<opioids>> <and> <<benzodiazepines>>. If we are unable to establish through communication with prescriber(s) that this individual's current use of prescription opioid medication(s) is appropriate, medically necessary, and safe, we may decide to place a limitation on their coverage of some or all of these medications. Therefore, your input is imperative.

We encourage you to use your state's Prescription Drug Monitoring Programs (PDMP) prior to prescribing to assess your patient's history of controlled substance use. The database may include additional controlled substance prescriptions not covered by this plan, such as those where the patient paid out of pocket. As an additional tool to consider in managing your patient's safe use of opioids, we would like to make you aware of the opioid reversal agent(s) available on the <Plan Name> formulary. We encourage you to consider co-prescribing an opioid reversal agent when prescribing opioids to your patients for their safety:

<Brand Name (Generic Name)>, <Tier> *[Add lines as appropriate]*

We thank you for your assistance in addressing this matter and urge you to be responsive. Please provide us with the information requested and/or return this page to us by <fax at ###> <indicate other method>.

Should you have any questions, or if you need additional information, please contact me at <Contact Information> during the hours of <LIST HOURS> and please refer to the file number above.

Sincerely,

<NAME AND CREDENTIAL OF CLINICAL STAFF>

[Insert beneficiary identifying information]

[List or attach the pertinent opioid/benzodiazepine prescription information].

[For beneficiaries identified has having a history of opioid overdose, suggested adding this or a similar statement: Based on a review of administrative claims, it appears <Beneficiary Name> may have experienced an opioid-related overdose event within the last 12 months and was prescribed opioids within the last 6 months.

PLEASE COMPLETE ALL THAT APPLY. THANK YOU FOR YOUR COOPERATION.

___ I would like <Plan Name> to contact me further to discuss this case, including relevant treatment information.

___ I, <Prescriber Name> am of the opinion that: 1) all these medications are appropriate, medically necessary, and safe for my patient, <Beneficiary Name>; and 2) <Beneficiary Name> **IS NOT** at-risk for prescription drug abuse or misuse.

___ I <Prescriber Name> am of the opinion that: 1) all of these medications are NOT appropriate, medically necessary, and safe for my patient, <Beneficiary Name>; and 2) <Beneficiary Name> **IS** at-risk for prescription drug abuse or misuse.

___I think <Plan Name> should be aware of the following relevant treatment information: