KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES			
Policy Title	Drug Management Program (DMP)	**Policy #**	13.33-P
Policy Owner	Pharmacy	**Original Effective Date**	01/01/2026
Revision Effective Date		**Approval Date**	3/16/2026
Line of Business	☐ Medi-Cal ☒ Medicare ☐ Corporate		

I. PURPOSE

To ensure that Kern Health System (KHS) performs necessary oversight and monitoring of the Drug Management Program (DMP), which is delegated to the Pharmacy Benefit Manager (PBM).

II. POLICY

KHS has established a policy to ensure access to the Centers for Medicare and Medicaid Services (CMS) Overutilization Monitoring System (OMS) and that OMS quarterly reports will be reviewed and required information/reports sent to CMS within thirty (30) days.

To comply with drug utilization management (UM) requirements as stated in 42.C.F.R. §423.153 et seq. KHS sponsors an Opiate Utilization Review Program to prevent overutilization of prescribed covered Part D drugs that focuses on case management of identified potential opioid over utilizers, including concurrent use with benzodiazepines.

III. DEFINITIONS

TERMS	DEFINITIONS
At-Risk Beneficiary (ARB)	At Risk Beneficiary is a Part D Member who is identified using clinical guidelines, who is not an exempted beneficiary, and determined to be at-risk for misuse or abuse of such frequently abused drugs. A. An ARB1 refers to a Member who is identified by KHS's DMP. B. An ARB2 is a Member who was identified as at-risk by the Part D plan he or she was most recently enrolled under, and the coverage limitations(s) on Frequently Abused Drugs (FADs) were implemented by the prior plan and had not been

	terminated upon Member's disenrollment.
CARA	Comprehensive Addiction and Recovery Act of 2016.
Centers for Medicare and Medicaid Services (CMS)	The Federal agency within the Department of Health and Human Services (DHHS) that administers the Medicare program and oversees all Medicare Advantage Plan (MAPD) and Prescription Drug Plan (PDP) organizations.
Drug Management Program (DMP)	Program to address Members at-risk for misuse or abuse of Frequently Abused Drugs (FADs).
D-SNP/SNP	Dual Special Needs Plan or Special Needs Plan. Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.
DTRR	Daily Transaction Reply Report
Exempted Beneficiaries	A Member who: One (1) has elected to receive hospice care or is receiving palliative or end-of-life care; Two (2) is a resident of a long-term care facility, of a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single Pharmacy; three (3) is being treated for cancer-related pain; or four (4) has a diagnosis of sickle-cell disease.
Frequently Abused Drugs (FADs)	List of controlled substances published by CMS determined to be frequently abused or diverted. This includes all opioids, with the exception of buprenorphine for medication-assisted treatment (MAT). Benzodiazepines are also considered FADs for the purposes of DMP. Clinical guidelines to determine at-risk status only consider the Member's opioid use.
Medicare Advantage Prescription Drug System (MARx)	One of the CMS Medicare Enrollment and Payment Systems, and the primary interface for Medicare organizations. It serves as the source for the enrollment and disenrollment information on Medicare beneficiaries.
Medication Overutilization	Any medication when used: A. In excessive dose, including duplicate therapy. B. For an excessive duration. C. Without adequate monitoring. D. Without adequate indications for its use. E. In the presence of adverse consequences indicating a reduction in dose, or a discontinuation of the medication. F. Or any combination of the reasons above.
Overutilization Monitoring System	A tool designed by CMS in July 2013 to oversee the compliance of Part D sponsors with CMS' opioid overutilization policy. The OMS

(OMS)	provides quarterly reports on high-risk Members identified by CMS and requires sponsors to report the outcomes of their review of each case. The system is part of a broader effort to address the overuse and abuse of opioids in the Medicare Part D program.
Overutilization Monitoring System (OMS) Criteria	Standards used by CMS annually to identify Part D beneficiaries whom CMS believes are at the highest risk of adverse events or overdose due to their level of opioid use, history of opioid-related overdose, and/or obtaining them from multiple prescribers/pharmacies.
ORF	Overutilization Monitoring Response Form
Potential At-Risk Beneficiary (PARB)	A Member who meets the OMS criteria and is not exempt from a DMP. A. A PARB1 refers to Member who meets the criteria with their current Medicare Part D plan. B. A PARB2 refers to a Member who has been identified as potentially at-risk by the DMP under his or her prior Part D plan, identified upon enrollment through the MARx system, but for whom a coverage limitation had not yet been implemented.
Sponsor Report Form (SRF)	Form used by plan sponsor to report overutilization monitoring cases.
TRC	Transaction Reply Code
Verification Response Form (VRF)	Form used by plan sponsor to verify/clarify overutilization monitoring cases that have potential data discrepancies between the OMS and MARx systems.

IV. PROCEDURES

A. The Opioid Medication Overutilization programs will comply with existing Coverage Determination, Appeal, and Grievance rules, as set forth at Title 42, Code of Federal Regulations (CFR), Part 423 Subpart M, and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

B. KHS's Drug Management Program will comply with applicable statutory and regulatory requirements, including 42 CFR § 423.153(f), and applicable guidance issued by the Centers for Medicare & Medicaid Services (CMS).

C. KHS will work with its PBM to establish drug utilization management and quality assurance measures and systems to reduce medication errors, minimize adverse drug interactions, and improve medication use.

D. KHS will work with its PBM to establish drug utilization management and quality assurance measures and systems to reduce medication errors, minimize adverse drug interactions, improve medication use, and address overutilization of frequently abused drugs.

1. Point-of-Sale (POS) Pharmacy Drug Utilization Review (DUR) edits include, but are not limited to the following:
    a. Opioid Cumulative Dosing at POS Pharmacy Edits.
        i. Pharmacy claims for Opioid class medications which exceed a cumulative Morphine Milligram Equivalent (MME) dose threshold, set by CMS, with a prescriber count of at least two (2) prescribers will trigger a rejection.
    b. Opioid-Buprenorphine Concurrent Use Limitation Edit.
        i. Pharmacy claims for Opioid class medications which are attempted to be filled when there is a fill for buprenorphine-containing products for Medication-Assisted Treatment (MAT) within the lookback period will trigger a rejection.
    c. Opioid-Naïve Day Supply Limitation Edit.
        i. Pharmacy claims for initial fills of Opioid class medications for the treatment of acute pain will be limited to no more than a seven (7)-day supply for Members with no Opioid history within the lookback period.
    d. Duplicate Long-Acting Opioid (LAO) Therapy at POS Edit.
        i. Pharmacy claims for long-acting Opioid class medications which are attempted to be filled when there is a fill for concurrent long-acting Opioid (excluding Buprenorphine) with a prescriber count of at least two (2) prescribers within the lookback period will trigger a rejection.

E. Member Identification:

1. KHS and its PBM will identify Members as At-Risk Beneficiaries (ARBs) or Potential At-Risk Beneficiaries (PARBs) via:
    a. MARx's Daily Transaction Reply Report (DTRR) – Identifies newly enrolled beneficiaries who were declared PARBs and/or ARBs by their previous Part D plan.
    b. OMS' quarterly PARB report – identifies Part D Members who meet OMS' PARB criteria.
    c. Internal claims data.
    d. Internal review of Members against OMS' PARB and ARB criteria.
    e. Care coordination with the Member's previous Part D plan.

2. According to the regulatory definition for an Exempted Beneficiary, a Member is automatically exempt from the DMP if:
    a. Member is being treated for active cancer-related pain.
    b. Member is receiving hospice care, non-hospice palliative care, or end-of-life care.

c. Member is a resident of a long-term care (LTC) facility, a facility described in section 1905(d) of the Social Security Act, or another facility for which Frequently Abused Drugs (FADs) are dispensed for residents through a contract with a single pharmacy.

d. Member has sickle cell disease.

F. Case management will be conducted by clinical staff or other appropriate health care professionals with sufficient expertise to conduct medical necessity reviews related to potential opioid overutilization.

1. The case management files will include documentation of all contact with the Prescriber, the Member and the pharmacy.

G. KHS and/or its PBM will evaluate the data and determine an appropriate intervention strategy based on criteria developed by CMS, the Pharmacy and Therapeutics (P&T) Committee, the unique characteristics of the specific Opioid Medication Overutilization issue, and collaboration with the provider(s) when applicable. Intervention strategies may include, but are not limited to:

1. Written notification to the PARB's relevant Opioid prescriber(s) regarding overutilization of FADs by the PARB with recommendations to optimize the medication regimen.

2. Member-level Drug/Quantity Limits

    a. Written notification will be sent to Prescribers, PARBs, and pharmacies (if applicable) of any member-level restrictions deemed necessary after case management.

3. Prescriber Limitations

4. Pharmacy Limitations

H. Member Preferences for Prescriber or Pharmacy Limitations

1. The ARB's Prescriber/pharmacy preferences (as long as in-network) shall be accepted unless it is determined that the selection would contribute to drug abuse or diversion.

2. If a Member submits preferences for Prescribers and/or pharmacies, written notification will be sent to Prescribers, ARBs, and pharmacies (if applicable) of the selection or change in selection in:

    a. Second Notice.

    b. If the Second Notice is not feasible due to the timing of the Member's submission, it will be sent in a subsequent written notice.

3. If it is determined that the Member's selection would contribute to drug abuse or diversion, written notice of change of selected Prescriber or Pharmacy with rationale will be sent to the ARB before changing the selections.

I. Member Notifications

1. Initial Notice

    a. Upon completion of case management, written notification of Potential At-Risk identification and the proposed coverage limitation will be sent to the PARB and the designated Prescriber.

    b. The notice shall comply with the applicable requirements of 42 CFR § 153(f)(5).

2. Second Notice

    a. If it is determined that a Member is in fact an ARB, a Second Notice of At-Risk determination and implementation of coverage limitation will be sent to the ARB, the designated Prescriber(s), and pharmacy(ies), if applicable, informing them of the Member's participation in the KHS DMP.

    b. A Second Notice is also sent to existing ARBs whose coverage limitation of FADs are extended for an additional year.

    c. The notice will comply with the applicable requirements of 42 CFR § 423.153(f)(6).

3. Alternative Second Notice

    a. If, after providing the Initial Notice, case management findings determine that PARB is an exempted beneficiary, the Member and prescribers(s) will receive an Alternative Second Notice informing them of this.

    b. If, after providing the Initial Notice, case management findings determine that PARB is not an ARB and no coverage limitation is warranted, the Member and prescriber(s) will receive an Alternative Second Notice informing them of this.

    c. The notice shall comply with the applicable requirements of 42 CFR § 423.153(f)(8).

J. Coverage Limitation Extensions

1. A limitation regarding an ARB may be extended for one additional year after the first year limitation subject to the following requirements:

    a. It is determined at the end of the first year of limitation that there is a clinical basis to extend the limitation.

    b. KHS and/or its PBM obtains the agreement of a prescriber of FADs for the ARB that the limitation should be extended, except that:

        i. A prescriber agreement is not required to extend a Pharmacy limitation.

        ii. If no prescriber was responsive after three attempts, a prescriber's agreement is not necessary to extend a Member-specific POS edit.

        iii. A Prescriber limitation may not be extended if no prescriber was responsive.

c. Another written Second Notice of At-Risk determination and implementation of coverage limitation will be sent to the ARB, the designated Prescriber(s), and pharmacy(ies), if applicable.

K. The identification of an ARB shall terminate as of the earlier of the following:

1. The date the Member demonstrates through subsequent determination (including but not limited to a successful Appeal) that the Member is no longer likely to be At-Risk in the absence of the limitation.

2. At the end of one of the following:

   a. The one-year period calculated from the effective date of the limitation (as specified in the Second Notice) unless the limitation was extended.

   b. The two-year period calculated from the effective date of the limitation (as specified in the Second Notice) if the limitation was extended.

L. Members who meet the definition of ARB or PARB and enroll or disenroll from the plan will be addressed promptly.

1. If a Member is identified as a PARB or an ARB by his or her most recent prior Part D plan and such identification has not been terminated, KHS is not required to engage in case management, as long as KHS and/or its PBM obtain case management information from the previous Part D plan and such information is still clinically adequate and up to date.

2. KHS and/or its PBM will respond to requests from other sponsors for information about ARBs and PARBs who recently disenrolled from KHS's DMP.

M. Delegated Oversight

1. KHS is responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other CMS guidelines and regulations. These requirements must be communicated by KHS to all delegated entities and subcontractors.

V. ATTACHMENTS

Attachment A:	Member Initial DMP Notice Letter
Attachment B:	Member Second DMP Notice Letter
Attachment C:	Member Alternate Second DMP Notice Letter
Attachment D:	Member Preference Confirmation Letter

Attachment E:	Member Preference Denial First Notice Letter
Attachment F:	Member Preference Denial Second Notice Letter
Attachment G:	Selected Pharmacy Confirmation Letter
Attachment H:	Prescriber Notice Cover Letter
Attachment I:	Prescriber Drug Utilization Evaluation (DUE) Letter – High Opioid Utilization
Attachment J:	Prescriber Drug Utilization Evaluation (DUE) Letter –Opioid-Benzo Combo
Attachment K:	Prescriber Opioid Overdose History Letter
Attachment L:	Prescriber Repeat Opioid Overdose Letter
Attachment M:	Selected Prescriber Confirmation Letter
Attachment N:	Prescriber Supplemental Drug Utilization Evaluation (DUE) Letter - Opioid-Benzo Combo
Attachment O:	Prescriber Supplemental Drug Utilization Evaluation (DUE) Letter – High Opioid Utilization

VI. REFERENCES

Reference Type:	Specific Reference:
Regulatory	CY 2023 DMP Guidance
Regulatory	Framework for DMP – Final Rule
Regulatory	Frequently Asked Questions (FAQs) About Drug Management Programs (DMPs) Revised November 28, 2022
Regulatory	Medicare Part D Reporting Requirements
Regulatory	OMS Report Samples
Regulatory	42 CFR § 423.153(f)(8), (f)(5), (f)(6)

VII. REVISION HISTORY

Action	Date	Brief Description of Updates	Author
Effective	01/01/2026	New Policy created to comply with D-SNP	M.C. Pharmacy

VIII. APPROVALS

Committees | Board (if applicable)	**Date Reviewed**	**Date Approved**
Choose an item.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

This is important information about your Medicare Part D prescription drug coverage. Read this notice carefully. For help, please contact us. Please see methods to contact us on the last page under "For More Information and Help with This Notice."

NOTICE OF INTENT TO LIMIT YOUR ACCESS TO CERTAIN PART D DRUGS

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

You are getting this notice because Kern Family Health Care Medicare (HMO D-SNP) believes your use of prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] may be unsafe. We plan to place you in our drug management program to better manage your use of these medications.

[Insert the following when at least one prescriber has responded:] {*Based on our review and communications with your prescribers(s),* [insert prescriber name(s)]*, unless we receive additional information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change as early as* [insert date 30 days from the date of this notice]*. The section "What If I Don't Agree?" tells you how to submit this information.*}

[Insert the following when no prescriber has responded:] {*We have contacted your prescriber(s),* [insert prescriber name(s)]*, about your use of these medications but have not received a reply. Unless we receive information from you or your prescriber(s) that assures us that your use of these medications is safe and appropriate, your access to these medications will change as early as* [insert date 30 days from the date of this notice]*. The section "What If I Don't Agree?" tells you how to submit this information.*}

What Action Do We Intend to Take?
Based on information available at the time of our review, we intend to limit your drug access in the following way(s), unless you provide us with information that changes our decision within 30 days of this notice:

_____

[Insert the following language as applicable:]

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following prescriber(s):*

[insert name, address and telephone number of prescriber(s)]

We will not cover these medications at the pharmacy when they are prescribed to you by other prescribers [MA-PDs insert if applicable: {*even if the other prescriber is in our network*}]. *You can ask us to use a different prescriber by contacting us or by filling out the form at the end of this notice.*

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following pharmacy(ies):*

[insert name, address and telephone number of pharmacy(ies)]

We will not cover these medications at another pharmacy, even if the other pharmacy is in the plan's network. You can ask us to use a different pharmacy by contacting us or by filling out the form at the end of this notice.}

{*We will only cover the following prescription opioid pain medication(s):* [list medications and amounts, if applicable]

We will not cover any other prescription opioid medications, even if they are included on the plan's drug list.}

{*We will only cover the following amount of prescription opioid pain medication(s):* [describe level that plan will cover]}

{*We will not cover any prescription opioid pain medication, including* [insert beneficiary's opioid medication name(s)]. *This includes opioids that are on the plan's drug list.*}

{*We will only cover the following benzodiazepines:* [list medications and amounts, if applicable]

We will not cover any other benzodiazepines, even if they are included on the plan's drug list.}

{*We will not cover any benzodiazepines, including* [insert beneficiary's benzodiazepine name(s)]. *This includes benzodiazepines that are on the plan's drug list.*}

This change only affects your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your access to other types of medications will not change.

[PACE organizations omit this section. Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*Can I Change Plans?*
Generally, no. As of [insert date of this notice]*, you can only change plans during the year in very limited situations, such as if you move out of the plan's service area or you lose or have a change in your Extra Help with your prescription drug costs. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.*}

What Is a Drug Management Program?
Kern Family Health Care Medicare (HMO D-SNP) has a drug management program to help you use prescription opioids safely. Opioids are a class of drugs that include pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple prescribers or pharmacies; when opioids are taken with certain other medications like benzodiazepines (commonly

used for anxiety and sleep); and/or when a person taking opioids has a recent history of opioid overdose. If we determine that your use of prescription opioids is not safe, we may limit your access to them or to other medications like benzodiazepines under our drug management program.

What If I Don't Agree?
You have the right to give us any information you think is important to our decision about the safety of your medication use.
[Insert this language if prescriber(s) have been non-responsive:] {*If you don't think the limitation(s) described above should apply to you, you should talk to your prescriber(s) about this notice. We contacted your prescriber(s),* [insert names of prescriber(s)]*, about your use of these medications but have not received a reply. Your prescriber(s) can also give us information about why the limitation(s) should not apply to you.*}

[Insert this language if prescriber(s) have been responsive:] {*In making our decision, we got information from your prescriber(s),* [insert names of prescriber(s)]*. If you don't think the limitation(s) described above should apply to you, please tell us why. We have shared a copy of this notice with your prescriber(s). You should also talk to them about this notice and next steps.*}

If you or your prescriber has information you would like us to consider, you can contact us at:

1-833-546-0101
1-844-713-1304
MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Ct.
San Diego, CA 92131

Note: We are not allowed to limit your access under the drug management program if you are being treated for cancer-related pain or have sickle cell disease, you're in hospice or get palliative or end-of-life care, or you live in a long-term care facility. If any of these apply to you or you have any other information you would like us to consider, please contact us within the next 30 days. See options to contact us in the section For More Information and Help with This Notice below.

[Insert this section for pharmacy and/or prescriber limitation:]
{***What If I Want to Use a Different*** **[insert as appropriate: {*Pharmacy*} or {*Prescriber*}, or {*Pharmacy or Prescriber*}]*?***
If you don't want to use the [insert as appropriate: {*pharmacy*} or {*prescriber*} or {*pharmacy or prescriber*}] *we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by contacting us at the phone number below.*}

What Happens Next?
We will review any information you send us. We will also review any new information from your prescriber(s). After we make a decision about whether you are safely using your medications, we will send you another notice within 60 days. You will receive another notice if we decide you're not at risk and will not limit your access to these drugs. You will also receive another notice if we decide you're at

risk and limit your access to these drugs. This notice will explain how you, your prescriber, or your representative can ask for an appeal and, if you choose to appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan.

Note: If you change to a different Medicare drug plan, we can give your new plan information about your case and any limitations we place on your drug access under our drug management program. Your new plan may place you in its drug management program as well.

What Resources Are Available to Help Me Use My Medications Safely?
The following benefits are available to you. They are at no cost if you use an in-network provider. They may require prior approval.

These services include:
- Individual and group therapy visits
- Opioid treatment program services
- Alcohol and Drug Screening, Assessment, Brief Interventions, and Referrals to Treatment (SABIRT)
- Inpatient medical detoxification, when medically necessary

You can access Drug Medi-Cal Organized Delivery System (DMC-ODS) services through Kern Behavioral Health and Recovery Services. For assistance, please contact the 24-Hour Substance Use Disorder Access Line at 1-866-266-4898.

Visit **www.hhs.gov/opioids** for information about State and Federal public health resources that can help you learn more about opioid medications and how to use them safely, including information about mental health services and other counseling services. Also visit Medicare's webpage **www.medicare.gov/coverage/pain-management** for information about Medicare's coverage of other pain treatments.

FOR MORE INFORMATION AND HELP WITH THIS NOTICE

For more information about the drug management program or any of the information in this notice, please contact Kern Family Health Care Medicare (HMO D-SNP) at:

Toll Free: 1-833-546-0101 TTY users: 711
24 hours a day, 365 days a year

www.kernfamilyhealthcare.com

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Ct.

San Diego, CA 92131

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-1465. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

[Include the following form when the enrollee has a pharmacy or prescriber limitation pending. This form is not required for point-of-sale edits.]

Kern Family Health Care Medicare (HMO D-SNP)
PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] *Member Number: [insert member ID]*

You can give us this information by calling us at 1-833-546-0101, faxing this form to us at 844-713-1304, or by sending the completed form to:

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Court
San Diego, CA 92131

I prefer to use the following pharmacy (write in the information for up to two, in order of preference):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (write in the information for up to two, in order of preference):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

}

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

This is important information about your Medicare Part D prescription drug coverage.
Read this notice carefully. For help, please contact us. Please see ways to contacts us on the last page under "For More Information and Help with This Notice."

YOUR ACCESS TO CERTAIN PART D DRUGS IS LIMITED

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

[Insert the following language UNLESS the plan is continuing an existing limitation from the enrollee's immediately prior plan:] {*On* [*insert date of initial notice*]*, we told you that we planned to limit your access to prescription* [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *through our drug management program. After completing our review, we have determined that your use of these drugs is unsafe.*}

[If the plan is continuing an existing limitation from the enrollee's immediately prior plan, insert the following language:] {*You are getting this notice because* your prior Medicare Part D plan, [Plan Name], *had placed you in its drug management program with a limitation(s) on your access to prescription* [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] for your *safety. Based on our review, including information obtained from your previous plan, we have also placed you in our drug management program.*}

What Action Have We Taken?
Effective [insert date] and continuing until [insert date], your access to medications is limited in the following way(s):

[Insert the following language as applicable:]

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following prescriber(s):*

[insert name, address and telephone number of prescriber(s)]

We will not cover these medications at the pharmacy when they are prescribed to you by other prescribers [MA-PDs insert if applicable: {*even if the other prescriber is in our network*}]. *You can ask us to use a different prescriber by contacting us or by filling out the form at the end of this notice.*}

{*You will be required to get your prescription* [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] *from the following pharmacy(ies):*

[insert name, address and telephone number of pharmacy(ies)]

We will not cover these medications at another pharmacy, even if the other pharmacy is in the plan's network. You can ask us to use a different pharmacy by contacting us or by filling out the form at the end of this notice.}

{*We will only cover the following prescription opioid pain medication(s):* [list medications and amounts, if applicable]

We will not cover any other prescription opioid medications, even if they are included on the plan's drug list.}

{*We will only cover the following amount of prescription opioid pain medication(s):* [describe level that plan will cover]}

{*We will not cover any prescription opioid pain medication, including* [insert beneficiary's opioid medication name(s)]. *This includes opioids that are on the plan's drug list.*}

{*We will only cover the following benzodiazepines:* [list medications and amounts, if applicable]

We will not cover any other benzodiazepines, even if they are included on the plan's drug list.}

{*We will not cover any benzodiazepines, including* [insert beneficiary's benzodiazepine name(s)]. *This includes benzodiazepines that are on the plan's drug list.*}

This change only affects your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your access to other types of medications will not change.

Why Did We Make This Decision?
[Provide specific rationale for the plan's decision that the enrollee is an at-risk beneficiary and the limitation(s) placed on the enrollee's access to frequently abused drugs under the drug management program. The rationale must include clinical criteria based on getting opioids from multiple prescribers or pharmacies and/or a recent history of an opioid overdose, Medicare coverage rule, Part D plan policy or other information on which the plan based its decision, including information obtained through case management or subsequent clinical contact with the enrollee's prescriber(s) of frequently abused drugs.

For decisions involving the continuation of a limitation under a drug management program from the enrollee's prior plan: the rationale must include an explanation, as applicable, that the plan's decision to continue the same limitation(s) as the prior plan was based in part on information obtained from the prior plan.]

Kern Family Health Care Medicare (HMO D-SNP)'s drug management program helps you use prescription opioids safely. Opioid pain can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple prescribers or pharmacies; when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep); and/or when a person taking opioids has a recent history of opioid overdose.

Visit **www.hhs.gov/opioids** for information about State and Federal public health resources that can

help you learn more about opioid medications and how to use them safely. Also visit Medicare's website about pain management at **https://www.medicare.gov/coverage/pain-management.**

[PACE organizations omit this section. Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*Can I Change Plans?*
Generally no. As of [insert date of initial notice], *you can only change plans during the year in very limited situations, such as you move out of the plan's service area or you lose or have a change in your Extra Help with your prescription drug costs. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.}*

[Insert this section for pharmacy and/or prescriber limitation:]
{***What If I Want to Use a Different*** **[insert as appropriate: {*Pharmacy*} or {*Prescriber*} or {*Pharmacy or Prescriber*}]*?***
If you don't want to use the [insert as appropriate: {*pharmacy*} or {*prescriber*} or {*pharmacy or prescriber*}] *we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by contacting us at the phone number below.}*

What If I Don't Agree with This Decision?
You have the right to appeal. You can appeal our decision to limit your access to prescription [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}], as well as any coverage determination made under a drug management program.

If you change to a new Medicare plan, we can give your new plan information about your case and the limits we have put on your access to prescription [insert as applicable: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. You also have the right to appeal our sharing of this information with the new plan.

If you want to appeal, you must request your appeal by [insert date 65 calendar days after the date of this notice]. We can give you more time if you have a good reason for missing the deadline.

Who May Request an Appeal?
You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at 1-833-546-0101 to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY 711.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us

to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**

- **If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.**

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?
You should include your name, address, Member number, the reasons for appealing, and any information you'd like us to consider. You may wish to talk with your prescriber about your appeal.

How Do I Request an Appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: 833-546-0101

Fax: 858-790-6060

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

MedImpact Healthcare Systems, Inc
Appeals and Grievance
10181 Scripps Gateway Court
San Diego, CA 92131

What Happens Next?
If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. If you disagree with that decision, you will have the right to another appeal. You will be notified of your appeal rights if this happens.

FOR MORE INFORMATION AND HELP WITH THIS NOTICE

For more information about the drug management program or any of the information in this notice, please contact Kern Family Health Care Medicare (HMO D-SNP) at:

Toll Free: 1-833-546-0101 TTY users: 711
24 hours a day/365 days a year

www.kernfamilyhealthcare.com

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Ct.
San Diego, CA 92131

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-TBD. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.
CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

[Include the following form when the member has a pharmacy or prescriber limitation pending. This form is not required for point-of-sale edits.]

Kern Family Health Care Medicare (HMO D-SNP)
PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] *Member Number: [insert member ID]*

You can give us this information by calling us at 1-833-546-0101, faxing this form to us at 844-713-1304, or by sending the completed form to:

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Court
San Diego, CA 92131

I prefer to use the following pharmacy (write in the information for up to two, in order of preference):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (write in the information for up to two, in order of preference):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

}

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Kern Family Health Care®
Medicare (D-SNP)

YOUR ACCESS TO CERTAIN PART D DRUGS WILL NOT BE LIMITED

Date: [insert date]

Enrollee's Name: [insert name] Member Number: [insert member ID]

On [Insert date of initial notice], we sent you a notice that we planned to limit your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}] through our drug management program.

After further review, we have decided that your access to these medications will NOT be limited under the drug management program. There are no changes to the way these medications are covered for you under our plan rules.

[Insert this section for Low Income Subsidy (LIS) beneficiaries:]
{*As of the date of this notice, you're eligible to use the quarterly Medicare Special Enrollment period because you receive Extra Help with your prescription drug costs. You can also change plans during other limited situations, such as if you move out of the plan's service area or you lose or have a change in your Extra Help. You can also change plans during the Annual Enrollment Period which occurs every year from October 15 – December 7.*}

If you have questions about this notice or our drug management program to help enrollees use prescription opioid medications safely, contact us at:

Kern Family Health Care Medicare (HMO D-SNP) Toll Free: 1-833-546-0101 TTY users: 711
24 hours a day, 365 days a year

www.kernfamilyhealthcare.com

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Ct.
San Diego, CA 92131

If you have questions about your opioid pain medication or other prescription drugs you are taking, speak with your prescriber.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-1465. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities: To request this form in an accessible format (e.g., Braille, Large Print, Audio CD) contact your Medicare Drug Plan. If you need assistance contacting your plan, call: 1-800-MEDICARE.

Kern Family Health Care
Medicare (D-SNP)

<MEMBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

<DATE>

Dear <MEMBER NAME>:

We received your request on <DATE> to update your preferred [select one: <pharmacy> or <prescriber> or <pharmacy and prescriber>] from which you may receive covered prescription [select one: <opioids> or <benzodiazepines> or <opioids and benzodiazepines>] under Kern Family Health Care Medicare (HMO D-SNP)'s Drug Management Program. This letter is to notify you that your preferences have been updated as of <EFFECTIVE DATE>.

Please note, this change only affects your coverage of prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your coverage of other types of medications will not change.

If you need to update these preferences in the future, you can give us this information by completing the last page of this notice and sending it to us, or by calling us at the phone number below.

Kern Family Health Care Medicare (HMO D-SNP)'s drug management program helps you use prescription opioids safely. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple doctors or pharmacies, and when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep).

If you have questions about this notice or our drug management program to help enrollees use prescription opioid medications safely, contact us at:

Toll Free: 1-833-546-0101 TTY users: 711
24 hours a day, 365 days a year

www.kernfamilyhealthcare.com

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Kern Family Health Care Medicare (HMO D-SNP) Pharmacy and Prescriber Selection Form

Enrollee's Name: [insert name] Member Number: [insert member ID]

You can give us this information by calling us at 1-833-546-0101, faxing this form to us at 844-713-1304, or by sending the completed form to:

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Court
San Diego, CA 92131

I prefer to use the following pharmacy (choose two):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (choose two):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

Kern Family Health Care
Medicare (D-SNP)

<MEMBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

<DATE>

Dear <MEMBER NAME>:

We received your request on <DATE> to update your preferred [select one: <pharmacy> or <prescriber> or <pharmacy and prescriber>] from which you may receive covered prescription [select one: <opioids> or <benzodiazepines> or <opioids and benzodiazepines>] under Kern Family Health Care Medicare (HMO D-SNP) 's Drug Management Program. Upon review, we have reason to believe that your choice of preferred prescriber and/or pharmacy may not support the safe use of opioids and/or benzodiazepines.

This letter is to notify you that we still intend to limit your coverage of these drugs in the manner outlined in the notice titled "NOTICE OF INTENT TO LIMIT YOUR ACCESS TO CERTAIN PART D DRUGS" which was mailed to you on MM/DD/YYYY and the change you have requested will not be implemented.

What Is A Drug Management Program?
Kern Family Health Care Medicare (HMO D-SNP) has a management program to help you use prescription opioids safely. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple doctors or pharmacies, and when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep). If we determine that your use of prescription opioids may not be safe, we may limit your access to them or to other medications like benzodiazepines.

What If I Don't Agree?
You have the right to give us any information you think is important to our decision about the safety of your medication use. If you or your prescriber has information you would like us to consider, you can contact us at:

Phone: 1-833-546-0101
Fax: (844) 713-1304
Address: MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Court
San Diego, CA 92131

Note: We are not allowed to limit your access under the drug management program if you are being treated for cancer-related pain or sickle cell disease, you're in hospice or get palliative or end-of-life care, or you live in a long-term care facility. If you have information you would like us to consider, please call us at the number above within the next 30 days.

What If I Want to Use a Different [insert as appropriate: {*Pharmacy*} or {*Prescriber*}, or {*Pharmacy or Prescriber?}*
If you don't want to use the [insert as appropriate: {*pharmacy*} or {*prescriber*} or {*pharmacy or prescriber*}] *we selected for you, you can ask to use a different one. You can give us this information by completing the last page of this notice and sending it to us, or by calling us at the phone number below.*}

What Happens Next?
We will review any information you send us. We will also review information from your prescriber(s). After we make a decision about whether you are safely using your medications, we will send you another notice within 60 days. If we decide you're at risk and limit your access to these drugs, we'll send you another notice explaining how you, your prescriber, or your representative can ask for an appeal. You will also receive a notice if we decide you're not at risk and will not limit your access to these drugs.

For More Information and Help with This Notice
For more information about the drug management program or any of the information in this notice, please contact Kern Family Health Care Medicare (HMO D-SNP) at:

Toll Free: 1-833-546-0101 TTY users: 711

24 hours a day, 365 days a year

www.kernfamilyhealthcare.com

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Kern Family Health Care Medicare (HMO D-SNP)
PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] Member Number: [insert member ID]

You can give us this information by calling us at 1-833-546-0101, faxing this form to us at 844-713-1304, or by sending the completed form to:

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Court
San Diego, CA 92131

I prefer to use the following pharmacy (choose two):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (choose two):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

Kern Family Health Care
Medicare (D-SNP)

<MEMBER NAME>
<ADDRESS>
<CITY, STATE ZIP>

<DATE>

Dear <MEMBER NAME>:

We received your request on <DATE> to update your preferred [select one: <pharmacy> or <prescriber> or <pharmacy and prescriber>] from which you may receive covered prescription [select one: <opioids> or <benzodiazepines> or <opioids and benzodiazepines>] under Kern Family Health Care Medicare (HMO D-SNP)'s Drug Management Program. Upon review, we have reason to believe that your choice of preferred prescriber and/or pharmacy may not support the safe use of opioids and/or benzodiazepines.

This letter is to notify you that your access to these drugs remains limited as outlined in the notice titled "YOUR ACCESS TO CERTAIN PART D DRUGS IS LIMITED" which was mailed to you on MM/DD/YYYY and the change you have requested has NOT been implemented.

If you wish to submit your preference for a different prescriber and/or pharmacy, you can give us this information by completing the last page of this notice and sending it to us, or by calling us at the phone number at the end of this notice.

Please note, this only affects your access to prescription [insert as appropriate: {*opioids*} or {*benzodiazepines*} or {*opioids and benzodiazepines*}]. Your access to other types of medications will not change.

What is a Drug Management Program?
Kern Family Health Care Medicare (HMO D-SNP) has a drug management program that helps you use prescription opioids safely. Opioid pain medications can help with certain types of pain, but have serious risks like addiction, overdose, and death. These risks are increased when opioids are obtained from multiple doctors or pharmacies, and when opioids are taken with certain other medications like benzodiazepines (commonly used for anxiety and sleep).

What If I Don't Agree With This Decision?
You have the right to appeal. You can appeal our decision to limit your access to covered prescription [insert as applicable: {opioids} or {benzodiazepines} or {opioids and benzodiazepines}], as well as any coverage determination made under a drug management program.

If you change to a new Medicare plan, we can give your new plan information about your case and the limits

we have put on your access to prescription [insert as applicable: {opioids} or {benzodiazepines} or {opioids and benzodiazepines}]. You also have the right to appeal our sharing of this information with the new plan.

If you want to appeal, you must request your appeal by [insert date 65 calendar days after the date of this notice]. We can give you more time if you have a good reason for missing the deadline.

Who May Request an Appeal?
You, your prescriber, or your representative may request an expedited (fast) or standard appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to be your representative. Others may already be authorized under State law to be your representative.

You can call us at 1-833-546-0101 to learn how to appoint a representative. If you have a hearing or speech impairment, please call us at TTY 711.

There Are Two Kinds of Appeals You Can Request

Expedited (72 hours): You, your prescriber, or your representative can request an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to 7 days for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.

- **If your prescriber** asks for an expedited appeal for you, or supports you in asking for one, and indicates that waiting for 7 days could seriously harm your health, **we will automatically expedite your appeal.**

- If you ask for an expedited appeal without support from your prescriber, we will decide if your health requires an expedited appeal. We will notify you if we do not give you an expedited appeal and we will decide your appeal within 7 days.

Standard (7 days): You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than 7 days after we get your appeal.

What Do I Include with My Appeal Request?
You should include your name, address, Member number, the reasons for appealing, and any information you'd like us to consider. You may wish to talk with your prescriber about your appeal.

How Do I Request an Appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: 1-833-546-0101

Fax: 1-858-790-6060

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

MedImpact Healthcare Systems, Inc
Appeals and Grievance
10181 Scripps Gateway Court
San Diego, CA 92131

What Happens Next?
If you appeal, we will review your case and give you a decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. If you disagree with that decision, you will have the right to another appeal. You will be notified of your appeal rights if this happens.

For More Information and Help with This Notice
If you have questions about this notice or our drug management program to help enrollees use prescription opioid medications safely, contact Kern Family Health Care Medicare (HMO D-SNP) at:

Toll Free: 1-833-546-0101 TTY users: 711

24 hours a day, 365 days a year

www.kernfamilyhealthcare.com

You may also contact one of the organizations listed below for assistance.

- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- State Health Insurance Program National Technical Assistance Center: 877-839-2675

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Kern Family Health Care Medicare (HMO D-SNP)
PHARMACY AND PRESCRIBER SELECTION FORM

Enrollee's Name: [insert name] Member Number: [insert member ID]

You can give us this information by calling us at 1-833-546-0101, faxing this form to us at 844-713-1304, or by sending the completed form to:

MedImpact Healthcare Systems, Inc.
Attn: DMP Dept. 1860
10181 Scripps Gateway Court
San Diego, CA 92131

I prefer to use the following pharmacy (choose two):

Choice #1

Pharmacy Name: _____

Address: _____

Telephone Number: _____

Choice #2

Pharmacy Name: _____

Address: _____

Telephone Number: _____

I prefer to use the following prescriber (choose two):

Choice #1

Prescriber Name: _____

Address: _____

Telephone Number: _____

Choice #2

Prescriber Name: _____

Address: _____

Telephone Number: _____

Kern Family Health Care
Medicare (D-SNP)

<PHARMACY NAME>
<ADDRESS>
<CITY, STATE ZIP>

Phone: <PHARMACY PHONE>
Fax: <PHARMACY FAX>

<DATE>

RE: <MEMBER NAME>
<MEMBER DOB>
<Member ID>

Dear <PHARMACY NAME>:

Recently, the Drug Management Program at Kern Family Health Care Medicare (HMO D-SNP) conducted a case management review on the utilization of opioids for <MEMBER NAME>. Based on our review, it was determined that the patient is at-risk for abuse or misuse of frequently abused drugs (FADs), and that a coverage limitation on opioids and/or benzodiazepines is deemed necessary. Specifically, it was determined that the patient should have a pharmacy limitation implemented to reduce his or her harm from abuse or misuse of these drugs.

We are contacting you today to notify you that your pharmacy has been chosen to serve as the patient's selected pharmacy for [select one: <opioids> or <benzodiazepines> or <opioids and benzodiazepines>]. This means that claims for any [select one: <opioids> or <benzodiazepines> or <opioids and benzodiazepines>] submitted for this patient must be processed by your pharmacy to be covered by our plan.

If your pharmacy does not agree to this selection, please submit your denial in writing and fax it to (844) 713-1304. If you have any questions or concerns with this letter, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm Pacific Standard Time.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Kern Family Health Care
Medicare (D-SNP)

March 16, 2026

«PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
«PHYSICIAN_ADDR_LINE_1»
«PHYSICIAN_ADDR_LINE_2»
«PHYSICIAN_CITY», «PHYSICIAN_STATE_CD» «PHYSICIAN_ZIP_CD»

RE: MEMBER_ID: «MEMBER_NO»

Dear Provider:

Kern Family Health Care Medicare (HMO D-SNP) is sending you this letter to provide a copy of a notice mailed to your patient, <MEMBER NAME>. It was determined that your patient [select one: <is at-risk> or <is not at-risk>] for abuse or misuse of frequently abused drugs (FADs), and that a coverage limitation on opioids and/or benzodiazepines [select one: <is> or <is not>] deemed necessary.

Should you have any questions, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm, Pacific Standard Time, and please refer to the Member ID above.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Attachments

Kern Family Health Care
Medicare (D-SNP)

March 16, 2026

«PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
«PHYSICIAN_ADDR_LINE_1»
«PHYSICIAN_ADDR_LINE_2»
«PHYSICIAN_CITY», «PHYSICIAN_STATE_CD» «PHYSICIAN_ZIP_CD»

RE: MEMBER_ID: «MEMBER_NO»

Dear Provider:

Kern Family Health Care Medicare (HMO D-SNP) is sending you this letter to request your assistance and response. Our Drug Management Program has determined that one of your patients is being prescribed a certain dosage of an opioid medication(s) and/or has opioid prescriptions involving multiple prescribers and/or pharmacies. Please review the attached list of medication(s) prescribed for your patient, which includes all opioid medications of which we are aware, the dosage(s) prescribed, and the time period we are reviewing.

Centers for Medicare and Medicaid Services (CMS) requires a utilization review when patients taking 90mg MME or higher from multiple providers or pharmacies are identified. In order to meet this requirement, we ask that you complete the attached brief questionnaire to confirm that the opioid medication(s) and current cumulative opioid dosages being prescribed for your patient are appropriate, medically necessary, and safe. **Please respond by filling out the following page and faxing it back to us at (844) 713-1304.** Also included are options you can elect to help in the management of your patient. These options include referral to a pain clinic, locking the member to a specific prescriber and/or pharmacy, and/or placing restrictions on the amount or type of opioid medication your patient can receive through their Medicare drug coverage.

We thank you for your assistance in addressing this matter and urge you to be responsive. If we are unable to establish that the current dosage of opioid medication(s) is appropriate, medically necessary, and safe, we may be required to restrict the beneficiary's coverage of some or all of these medications.

Should you have any questions, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm, Pacific Standard Time, and please refer to the Member ID above.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)
Attachments

Kern Family Health Care
Medicare (D-SNP)

Please fax this form back to us at (844) 713-1304

March 16, 2026

Provider Name: «PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»

Provider Phone: «PHYSICIAN_PHONE»

Provider Fax: «PHYSICIAN_FAX»

RE: Member: «MEMBER_FULL_NAME»
Member ID: «MEMBER_NO»
DOB: «BIRTH_DT»

Drug Utilization Evaluation Program: Opioid Overutilization

Your feedback is essential for this drug utilization review

Please mark all applicable statements:

- ❑ Patient is **NOT** at-risk for drug abuse or misuse. The drug therapy is appropriate, medically necessary, and safe for treatment of (*please check all that apply*):
  - ❑ Cancer ❑ Sickle Cell Disease ❑ Severe pain due to _____
  - ❑ Post-surgery ❑ Other: _____
- ❑ Patient is currently in hospice, receiving palliative care, or residing in a long-term care facility.
- ❑ I am aware of the patient's opioid use and will manage/coordinate the beneficiary's FAD (frequently abused drug) use.
- ❑ This is **NOT my patient**. My records show this patient's primary care provider is *(please list if known)* _____
- ❑ I did **NOT** prescribe the following medication(s) associated with my DEA or NPI number. *(If the wrong physician's name, DEA or NPI number is linked to the prescription at the pharmacy, the patient may have been improperly identified as yours.)* My records show this patient's primary care provider is *(please list if known)*: _____
- ❑ Patient **IS** at-risk for drug abuse or misuse.
  - **Note**: If you indicate the patient **IS** at-risk, the medication management pharmacist will call you to discuss the possibility to restrict the member to a specific prescriber and/or pharmacy or limit the quantity or type of opioid medication your patient can receive through their Medicare drug coverage.
- ❑ I would like to discuss this profile with the medication management pharmacist. *(Please include the best contact name and number for your office).* _____

Questions or comments: _____

Kern Family Health Care®
Medicare (D-SNP)

Signature: _____ Date: _____

Kern Family Health Care®
Medicare (D-SNP)

Member Name: «MEMBER_FULL_NAME» Member #: «MEMBER_NO» Birth Date: «BIRTH_DT»
Average MED: «AVG_MME» Plan Sponsor: «CARRIER_HQ_NAME»

Fill Date	Brand/Strength	Dosage Form	Qty	Days Supply	Provider
«FILL_DT1»	«BRAND_STRENGTH1»	«DOSAGE_FORM1»	«QTY_SUPPLY1»	«DAYS_SUPPLY1»	«PHYSICIAN_FULL_NAME_CLAIM1»
«FILL_DT2»	«BRAND_STRENGTH2»	«DOSAGE_FORM2»	«QTY_SUPPLY2»	«DAYS_SUPPLY2»	«PHYSICIAN_FULL_NAME_CLAIM2»
«FILL_DT3»	«BRAND_STRENGTH3»	«DOSAGE_FORM3»	«QTY_SUPPLY3»	«DAYS_SUPPLY3»	«PHYSICIAN_FULL_NAME_CLAIM3»
«FILL_DT4»	«BRAND_STRENGTH4»	«DOSAGE_FORM4»	«QTY_SUPPLY4»	«DAYS_SUPPLY4»	«PHYSICIAN_FULL_NAME_CLAIM4»
«FILL_DT5»	«BRAND_STRENGTH5»	«DOSAGE_FORM5»	«QTY_SUPPLY5»	«DAYS_SUPPLY5»	«PHYSICIAN_FULL_NAME_CLAIM5»
«FILL_DT6»	«BRAND_STRENGTH6»	«DOSAGE_FORM6»	«QTY_SUPPLY6»	«DAYS_SUPPLY6»	«PHYSICIAN_FULL_NAME_CLAIM6»
«FILL_DT7»	«BRAND_STRENGTH7»	«DOSAGE_FORM7»	«QTY_SUPPLY7»	«DAYS_SUPPLY7»	«PHYSICIAN_FULL_NAME_CLAIM7»
«FILL_DT8»	«BRAND_STRENGTH8»	«DOSAGE_FORM8»	«QTY_SUPPLY8»	«DAYS_SUPPLY8»	«PHYSICIAN_FULL_NAME_CLAIM8»
«FILL_DT9»	«BRAND_STRENGTH9»	«DOSAGE_FORM9»	«QTY_SUPPLY9»	«DAYS_SUPPLY9»	«PHYSICIAN_FULL_NAME_CLAIM9»
«FILL_DT10»	«BRAND_STRENGTH10»	«DOSAGE_FORM10»	«QTY_SUPPLY10»	«DAYS_SUPPLY10»	«PHYSICIAN_FULL_NAME_CLAIM10»
«FILL_DT11»	«BRAND_STRENGTH11»	«DOSAGE_FORM11»	«QTY_SUPPLY11»	«DAYS_SUPPLY11»	«PHYSICIAN_FULL_NAME_CLAIM11»
«FILL_DT12»	«BRAND_STRENGTH12»	«DOSAGE_FORM12»	«QTY_SUPPLY12»	«DAYS_SUPPLY12»	«PHYSICIAN_FULL_NAME_CLAIM12»
«FILL_DT13»	«BRAND_STRENGTH13»	«DOSAGE_FORM13»	«QTY_SUPPLY13»	«DAYS_SUPPLY13»	«PHYSICIAN_FULL_NAME_CLAIM13»
«FILL_DT14»	«BRAND_STRENGTH14»	«DOSAGE_FORM14»	«QTY_SUPPLY14»	«DAYS_SUPPLY14»	«PHYSICIAN_FULL_NAME_CLAIM14»
«FILL_DT15»	«BRAND_STRENGTH15»	«DOSAGE_FORM15»	«QTY_SUPPLY15»	«DAYS_SUPPLY15»	«PHYSICIAN_FULL_NAME_CLAIM15»
«FILL_DT16»	«BRAND_STRENGTH16»	«DOSAGE_FORM16»	«QTY_SUPPLY16»	«DAYS_SUPPLY16»	«PHYSICIAN_FULL_NAME_CLAIM16»

Kern Family Health Care
Medicare (D-SNP)

«FILL_DT17»	«BRAND_STRENGTH17»	«DOSAGE_FORM17»	«QTY_SUPPLY17»	«DAYS_SUPPLY17»	«PHYSICIAN_FULL_NAME_CLAIM17»
«FILL_DT18»	«BRAND_STRENGTH18»	«DOSAGE_FORM18»	«QTY_SUPPLY18»	«DAYS_SUPPLY18»	«PHYSICIAN_FULL_NAME_CLAIM18»
«FILL_DT19»	«BRAND_STRENGTH19»	«DOSAGE_FORM19»	«QTY_SUPPLY19»	«DAYS_SUPPLY19»	«PHYSICIAN_FULL_NAME_CLAIM19»
«FILL_DT20»	«BRAND_STRENGTH20»	«DOSAGE_FORM20»	«QTY_SUPPLY20»	«DAYS_SUPPLY20»	«PHYSICIAN_FULL_NAME_CLAIM20»

Kern Family Health Care
Medicare (D-SNP)

March 16, 2026

«PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
«PHYSICIAN_ADDR_LINE_1»
«PHYSICIAN_ADDR_LINE_2»
«PHYSICIAN_CITY», «PHYSICIAN_STATE_CD» «PHYSICIAN_ZIP_CD»

RE: MEMBER_ID: «MEMBER_NO»

Dear Provider:

Kern Family Health Care Medicare (HMO D-SNP) is sending you this letter to request your assistance and response. Our Drug Management Program has determined that a patient under your care is being prescribed a certain dosage of an opioid medication(s) and/or has opioid prescriptions involving multiple prescribers and/or pharmacies. In addition, your patient has also utilized a benzodiazepine and/or gabapentinoid concurrently with an opioid medication.

The Centers for Medicare & Medicaid Services (CMS) **requires** a drug utilization review when patients taking 90mg MME or higher from multiple providers or pharmacies are identified. This review also includes the patient's concurrent use of opioids with benzodiazepines, gabapentin (in daily doses exceeding 2,400mg/day) or pregabalin. The combination of opioids and benzodiazepines can cause extreme sleepiness and exacerbate respiratory depression, the primary factor in fatal opioid overdose. The risk of opioid-related morbidity and mortality is increased in all patients, even those who do not show signs of aberrant drug behavior. Furthermore, the Centers for Disease Control (CDC) advises clinicians to avoid prescribing opioids and benzodiazepines concurrently whenever possible.[1] In addition, gabapentinoids have been identified as potentiator drugs that may pose safety risks when misused with opioids. They have also been identified as an independent risk factor for opioid-related deaths and is reportedly misused due to the euphoria associated with use at high doses.

Attached is a list of opioid pain medications, benzodiazepines, and/or gabapentinoids prescribed for your patient, which includes all medications of which we are aware, the dosage(s) prescribed, and the time period we are reviewing.

We ask that you complete the attached questionnaire to confirm that the opioid medication(s) and current cumulative opioid dosages being prescribed for your patient are appropriate, medically necessary, and safe. Also, please provide the current treatment plan for your patient's concurrent opioid, benzodiazepine, and/or gabapentinoid therapy, as indicated. **Please respond by filling out the following page and faxing it back to us at (844) 713-1304.**

We thank you for your assistance in addressing this matter. We urge you to be responsive as your input is imperative. Should you have any questions, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 the hours of 9am to 5pm, Pacific Standard Time, and please refer to the Member ID above.

Sincerely,

[Kern Family Health Care Medicare (HMO D-SNP)

Attachments

[1] http://www.cdc.gov/drugoverdose/prescribing/guideline.html

Kern Family Health Care
Medicare (D-SNP)

Please fax this form back to us at (844) 713-1304

March 16, 2026

Provider Name: «PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
Provider Phone: «PHYSICIAN_PHONE»
Provider FAX: «PHYSICIAN_FAX»

RE: Member: «MEMBER_FULL_NAME»
Member ID: «MEMBER_NO»
DOB: «BIRTH_DT»

Drug Utilization Evaluation Program: Opioid Overutilization

Your feedback is essential for this drug utilization review.

Please provide details of patient's opioid drug therapy: *Select all statements that apply*

- ❑ Patient is **NOT** at-risk for prescription drug abuse or misuse. The opioid drug therapy is appropriate, medically necessary, and safe for the treatment of (*please check all that apply*):
  - ❑ Cancer ❑ Sickle Cell Disease ❑ Severe pain due to _____
  - ❑ Post-surgery ❑ Other: _____
- ❑ Patient is in hospice, receiving palliative care, or is residing in a long-term care facility.
- ❑ I am aware of the patient's opioid and benzodiazepine and/or gabapentinoid use and will manage/coordinate the beneficiary's FAD (frequently abused drug) use.
- ❑ This is **NOT my patient**. My records show this patient's primary care provider is *(please list if known)* _____
- ❑ I did **NOT** prescribe the following medication(s) associated with my DEA or NPI number. *(If the wrong physician's name, DEA or NPI number is linked to the prescription at the pharmacy, the patient may have been improperly identified as yours.)* My records show this patient's primary care provider is *(please list if known):* _____ _____
- ❑ Patient **IS** at-risk for prescription drug abuse or misuse. **Note**: If you indicate the patient **IS** at-risk, the medication management pharmacist will call you to discuss the possibility to restrict the member to a specific prescriber and/or pharmacy or limit the quantity or type of opioid medication your patient can receive through their Medicare drug coverage.

Please provide details of patient's benzodiazepine drug therapy (if applicable):

- ❑ The concurrent use of benzodiazepines with opioids is medically necessary due to (*please include diagnosis*): _____
- ❑ Benzodiazepine therapy will be:
  - ❑ Tapered ❑ Discontinued ❑ Changed to:_____

Please provide details of patient's pregabalin or gabapentin drug therapy (if applicable):

- ❑ The concurrent use of pregabalin or gabapentin with opioids is medically necessary due to (*please include diagnosis*): _____
- ❑ Pregabalin or gabapentin therapy will be:
  - ❑ Tapered ❑ Discontinued ❑ Changed to:_____

- ❑ I would like to discuss this profile with the medication management pharmacist. *(Please include the best contact name and number for your office)*. _____

Questions or comments: _____

Kern Family Health Care®
Medicare (D-SNP)

Signature: _____ Date: _____

Member Name: «MEMBER_FULL_NAME» Member #: «MEMBER_NO» Birth Date: «BIRTH_DT»
Average MME: «AVG_MME» Plan Sponsor: «CARRIER_HQ_NAME»

Fill Date	Brand/Strength	Dosage Form	Qty	Days Supply	Provider
«FILL_DT1»	«BRAND_STRENGTH1»	«DOSAGE_FORM1»	«QTY_SUPPLY1»	«DAYS_SUPPLY1»	«PHYSICIAN_FULL_NAME_CLAIM1»
«FILL_DT2»	«BRAND_STRENGTH2»	«DOSAGE_FORM2»	«QTY_SUPPLY2»	«DAYS_SUPPLY2»	«PHYSICIAN_FULL_NAME_CLAIM2»
«FILL_DT3»	«BRAND_STRENGTH3»	«DOSAGE_FORM3»	«QTY_SUPPLY3»	«DAYS_SUPPLY3»	«PHYSICIAN_FULL_NAME_CLAIM3»
«FILL_DT4»	«BRAND_STRENGTH4»	«DOSAGE_FORM4»	«QTY_SUPPLY4»	«DAYS_SUPPLY4»	«PHYSICIAN_FULL_NAME_CLAIM4»
«FILL_DT5»	«BRAND_STRENGTH5»	«DOSAGE_FORM5»	«QTY_SUPPLY5»	«DAYS_SUPPLY5»	«PHYSICIAN_FULL_NAME_CLAIM5»
«FILL_DT6»	«BRAND_STRENGTH6»	«DOSAGE_FORM6»	«QTY_SUPPLY6»	«DAYS_SUPPLY6»	«PHYSICIAN_FULL_NAME_CLAIM6»
«FILL_DT7»	«BRAND_STRENGTH7»	«DOSAGE_FORM7»	«QTY_SUPPLY7»	«DAYS_SUPPLY7»	«PHYSICIAN_FULL_NAME_CLAIM7»
«FILL_DT8»	«BRAND_STRENGTH8»	«DOSAGE_FORM8»	«QTY_SUPPLY8»	«DAYS_SUPPLY8»	«PHYSICIAN_FULL_NAME_CLAIM8»
«FILL_DT9»	«BRAND_STRENGTH9»	«DOSAGE_FORM9»	«QTY_SUPPLY9»	«DAYS_SUPPLY9»	«PHYSICIAN_FULL_NAME_CLAIM9»
«FILL_DT10»	«BRAND_STRENGTH10»	«DOSAGE_FORM10»	«QTY_SUPPLY10»	«DAYS_SUPPLY10»	«PHYSICIAN_FULL_NAME_CLAIM10»
«FILL_DT11»	«BRAND_STRENGTH11»	«DOSAGE_FORM11»	«QTY_SUPPLY11»	«DAYS_SUPPLY11»	«PHYSICIAN_FULL_NAME_CLAIM11»
«FILL_DT12»	«BRAND_STRENGTH12»	«DOSAGE_FORM12»	«QTY_SUPPLY12»	«DAYS_SUPPLY12»	«PHYSICIAN_FULL_NAME_CLAIM12»
«FILL_DT13»	«BRAND_STRENGTH13»	«DOSAGE_FORM13»	«QTY_SUPPLY13»	«DAYS_SUPPLY13»	«PHYSICIAN_FULL_NAME_CLAIM13»
«FILL_DT14»	«BRAND_STRENGTH14»	«DOSAGE_FORM14»	«QTY_SUPPLY14»	«DAYS_SUPPLY14»	«PHYSICIAN_FULL_NAME_CLAIM14»
«FILL_DT15»	«BRAND_STRENGTH15»	«DOSAGE_FORM15»	«QTY_SUPPLY15»	«DAYS_SUPPLY15»	«PHYSICIAN_FULL_NAME_CLAIM15»
«FILL_DT16»	«BRAND_STRENGTH16»	«DOSAGE_FORM16»	«QTY_SUPPLY16»	«DAYS_SUPPLY16»	«PHYSICIAN_FULL_NAME_CLAIM16»
«FILL_DT17»	«BRAND_STRENGTH17»	«DOSAGE_FORM17»	«QTY_SUPPLY17»	«DAYS_SUPPLY17»	«PHYSICIAN_FULL_NAME_CLAIM17»

Kern Family Health Care®
Medicare (D-SNP)

«FILL_DT18»	«BRAND_STRENGTH18»	«DOSAGE_FORM18»	«QTY_SUPPLY18»	«DAYS_SUPPLY18»	«PHYSICIAN_FULL_NAME_CLAIM18»
«FILL_DT19»	«BRAND_STRENGTH19»	«DOSAGE_FORM19»	«QTY_SUPPLY19»	«DAYS_SUPPLY19»	«PHYSICIAN_FULL_NAME_CLAIM19»
«FILL_DT20»	«BRAND_STRENGTH20»	«DOSAGE_FORM20»	«QTY_SUPPLY20»	«DAYS_SUPPLY20»	«PHYSICIAN_FULL_NAME_CLAIM20»
«FILL_DT21»	«BRAND_STRENGTH21»	«DOSAGE_FORM21»	«QTY_SUPPLY21»	«DAYS_SUPPLY21»	«PHYSICIAN_FULL_NAME_CLAIM21»
«FILL_DT22»	«BRAND_STRENGTH22»	«DOSAGE_FORM22»	«QTY_SUPPLY22»	«DAYS_SUPPLY22»	«PHYSICIAN_FULL_NAME_CLAIM22»
«FILL_DT23»	«BRAND_STRENGTH23»	«DOSAGE_FORM23»	«QTY_SUPPLY23»	«DAYS_SUPPLY23»	«PHYSICIAN_FULL_NAME_CLAIM23»
«FILL_DT24»	«BRAND_STRENGTH24»	«DOSAGE_FORM24»	«QTY_SUPPLY24»	«DAYS_SUPPLY24»	«PHYSICIAN_FULL_NAME_CLAIM24»
«FILL_DT25»	«BRAND_STRENGTH25»	«DOSAGE_FORM25»	«QTY_SUPPLY25»	«DAYS_SUPPLY25»	«PHYSICIAN_FULL_NAME_CLAIM25»
«FILL_DT26»	«BRAND_STRENGTH26»	«DOSAGE_FORM26»	«QTY_SUPPLY26»	«DAYS_SUPPLY26»	«PHYSICIAN_FULL_NAME_CLAIM26»

Kern Family Health Care
Medicare (D-SNP)

March 16, 2026

«PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
«PHYSICIAN_ADDR_LINE_1»
«PHYSICIAN_ADDR_LINE_2»
«PHYSICIAN_CITY», «PHYSICIAN_STATE_CD» «PHYSICIAN_ZIP_CD»

RE: MEMBER_ID: «MEMBER_NO»

Dear Provider:

Kern Family Health Care Medicare (HMO D-SNP) is sending you this letter to request your assistance and response. Our Drug Management Program has determined that one of your patients has a history of opioid-related overdose in the last 12 months and was prescribed opioids in the last 6 months. Please review the attached list of medication(s) prescribed for your patient, which includes all opioid medications of which we are aware, the dosage(s) prescribed, and the time period we are reviewing.

Centers for Medicare and Medicaid Services (CMS) requires a utilization review when patients have a history of opioid-related overdose in the last 12 months and an opioid prescription in the last 6 months. In order to meet this requirement, we ask that you complete the attached brief questionnaire to confirm that the opioid medication(s) and current cumulative opioid dosages being prescribed for your patient are appropriate, medically necessary, and safe. **Please respond by filling out the following page and faxing it back to us at (844) 713-1304.** Also included are options you can elect to help in the management of your patient. These options include referral to a pain clinic, locking the member to a specific prescriber and/or pharmacy, and/or placing restrictions on the amount or type of opioid medication your patient can receive through their Medicare drug coverage.

We thank you for your assistance in addressing this matter and urge you to be responsive. If we are unable to establish that the current use of opioid medication(s) is appropriate, medically necessary, and safe, we may be required to restrict the beneficiary's coverage of some or all of these medications.

Should you have any questions, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm, Pacific Standard Time, and please refer to the Member ID above.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Attachments

Kern Family Health Care
Medicare (D-SNP)

Please fax this form back to us at (844) 713-1304

March 16, 2026

Provider Name: «PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»

Provider Phone: «PHYSICIAN_PHONE»

Provider Fax: «PHYSICIAN_FAX»

RE: Member: «MEMBER_FULL_NAME»

Member ID: «MEMBER_NO»

DOB: «BIRTH_DT»

Drug Utilization Evaluation Program: Opioid Overutilization

Your feedback is essential for this drug utilization review

Please mark all applicable statements:

- ❑ Patient is **NOT** at-risk for drug abuse or misuse. The drug therapy is appropriate, medically necessary, and safe for treatment of (please check all that apply):
  - ❑ Cancer ❑ Sickle Cell Disease ❑ Severe pain due to _____
  - ❑ Post-surgery ❑ Other: _____
- ❑ Patient is currently in hospice, receiving palliative care, or residing in a long-term care facility.
- ❑ I am aware of the patient's history of opioid-related overdose with prescription opioid use and will manage/coordinate the beneficiary's FAD (frequently abused drug) use.
- ❑ This is **NOT my patient**. My records show this patient's primary care provider is *(please list if known)* _____
- ❑ I did **NOT** prescribe the following medication(s) associated with my DEA or NPI number. *(If the wrong physician's name, DEA or NPI number is linked to the prescription at the pharmacy, the patient may have been improperly identified as yours.)* My records show this patient's primary care provider is *(please list if known)*: _____
- ❑ Patient **IS** at-risk for drug abuse or misuse.
  - **Note**: If you indicate the patient **IS** at-risk, the medication management pharmacist will call you to discuss the possibility to restrict the member to a specific prescriber and/or pharmacy or limit the quantity or type of opioid medication your patient can receive through their Medicare drug coverage.
- ❑ I would like to discuss this profile with the medication management pharmacist. (*Please include the best contact name and number for your office.)* _____

Questions or comments: _____

Signature: _____ Date: _____

Kern Family Health Care
Medicare (D-SNP)

Member Name: «MEMBER_FULL_NAME» Member #: «MEMBER_NO» Birth Date: «BIRTH_DT»

Average MED: «AVG_MME» Plan Sponsor: «CARRIER_HQ_NAME»

Fill Date	Brand/Strength	Dosage Form	Qty	Days Supply	Provider
«FILL_DT1»	«BRAND_STRENGTH1»	«DOSAGE_FORM1»	«QTY_SUPPLY1»	«DAYS_SUPPLY1»	«PHYSICIAN_FULL_NAME_CLAIM1»
«FILL_DT2»	«BRAND_STRENGTH2»	«DOSAGE_FORM2»	«QTY_SUPPLY2»	«DAYS_SUPPLY2»	«PHYSICIAN_FULL_NAME_CLAIM2»
«FILL_DT3»	«BRAND_STRENGTH3»	«DOSAGE_FORM3»	«QTY_SUPPLY3»	«DAYS_SUPPLY3»	«PHYSICIAN_FULL_NAME_CLAIM3»
«FILL_DT4»	«BRAND_STRENGTH4»	«DOSAGE_FORM4»	«QTY_SUPPLY4»	«DAYS_SUPPLY4»	«PHYSICIAN_FULL_NAME_CLAIM4»
«FILL_DT5»	«BRAND_STRENGTH5»	«DOSAGE_FORM5»	«QTY_SUPPLY5»	«DAYS_SUPPLY5»	«PHYSICIAN_FULL_NAME_CLAIM5»
«FILL_DT6»	«BRAND_STRENGTH6»	«DOSAGE_FORM6»	«QTY_SUPPLY6»	«DAYS_SUPPLY6»	«PHYSICIAN_FULL_NAME_CLAIM6»
«FILL_DT7»	«BRAND_STRENGTH7»	«DOSAGE_FORM7»	«QTY_SUPPLY7»	«DAYS_SUPPLY7»	«PHYSICIAN_FULL_NAME_CLAIM7»
«FILL_DT8»	«BRAND_STRENGTH8»	«DOSAGE_FORM8»	«QTY_SUPPLY8»	«DAYS_SUPPLY8»	«PHYSICIAN_FULL_NAME_CLAIM8»
«FILL_DT9»	«BRAND_STRENGTH9»	«DOSAGE_FORM9»	«QTY_SUPPLY9»	«DAYS_SUPPLY9»	«PHYSICIAN_FULL_NAME_CLAIM9»
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«FILL_DT11»	«BRAND_STRENGTH11»	«DOSAGE_FORM11»	«QTY_SUPPLY11»	«DAYS_SUPPLY11»	«PHYSICIAN_FULL_NAME_CLAIM11»
«FILL_DT12»	«BRAND_STRENGTH12»	«DOSAGE_FORM12»	«QTY_SUPPLY12»	«DAYS_SUPPLY12»	«PHYSICIAN_FULL_NAME_CLAIM12»
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«FILL_DT14»	«BRAND_STRENGTH14»	«DOSAGE_FORM14»	«QTY_SUPPLY14»	«DAYS_SUPPLY14»	«PHYSICIAN_FULL_NAME_CLAIM14»
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«FILL_DT16»	«BRAND_STRENGTH16»	«DOSAGE_FORM16»	«QTY_SUPPLY16»	«DAYS_SUPPLY16»	«PHYSICIAN_FULL_NAME_CLAIM16»
«FILL_DT17»	«BRAND_STRENGTH17»	«DOSAGE_FORM17»	«QTY_SUPPLY17»	«DAYS_SUPPLY17»	«PHYSICIAN_FULL_NAME_CLAIM17»

Kern Family Health Care
Medicare (D-SNP)

«FILL_DT18»	«BRAND_STRENGTH18»	«DOSAGE_FORM18»	«QTY_SUPPLY18»	«DAYS_SUPPLY18»	«PHYSICIAN_FULL_NAME_CLAIM18»
«FILL_DT19»	«BRAND_STRENGTH19»	«DOSAGE_FORM19»	«QTY_SUPPLY19»	«DAYS_SUPPLY19»	«PHYSICIAN_FULL_NAME_CLAIM19»
«FILL_DT20»	«BRAND_STRENGTH20»	«DOSAGE_FORM20»	«QTY_SUPPLY20»	«DAYS_SUPPLY20»	«PHYSICIAN_FULL_NAME_CLAIM20»

Kern Family Health Care®
Medicare (D-SNP)

March 16, 2026

«PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
«PHYSICIAN_ADDR_LINE_1»
«PHYSICIAN_ADDR_LINE_2»
«PHYSICIAN_CITY», «PHYSICIAN_STATE_CD» «PHYSICIAN_ZIP_CD»

RE: MEMBER_ID: «MEMBER_NO»

Dear Provider:

Kern Family Health Care Medicare (HMO D-SNP) is sending you this letter to request your assistance and response. Our Drug Management Program has determined that one of your patients had another claim for opioid-related overdose in the last 12 months and was prescribed opioids in the last 6 months. Please review the attached list of medication(s) prescribed for your patient, which includes all opioid medications of which we are aware, the dosage(s) prescribed, and the time period we are reviewing.

Centers for Medicare and Medicaid Services (CMS) requires a utilization review when patients have a history of opioid-related overdose in the last 12 months and an opioid prescription in the last 6 months. Patients may require another utilization review if there is a new opioid-related overdose claim after the 12-month period in which they were originally identified. In order to meet this requirement, we ask that you complete the attached brief questionnaire to confirm that the opioid medication(s) and current cumulative opioid dosages being prescribed for your patient are appropriate, medically necessary, and safe. **Please respond by filling out the following page and faxing it back to us at (844) 713-1304.** Also included are options you can elect to help in the management of your patient. These options include referral to a pain clinic, locking the member to a specific prescriber and/or pharmacy, and/or placing restrictions on the amount or type of opioid medication your patient can receive through their Medicare drug coverage.

We thank you for your assistance in addressing this matter and urge you to be responsive. If we are unable to establish that the current use of opioid medication(s) is appropriate, medically necessary, and safe, we may be required to restrict the beneficiary's coverage of some or all of these medications.

Should you have any questions, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm, Pacific Standard Time, and please refer to the Member ID above.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)
Attachments

Kern Family Health Care
Medicare (D-SNP)

Please fax this form back to us at (844) 713-1304

March 16, 2026

Provider Name: «PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»

Provider Phone: «PHYSICIAN_PHONE»

Provider Fax: «PHYSICIAN_FAX»

RE: Member: «MEMBER_FULL_NAME»
Member ID: «MEMBER_NO»
DOB: «BIRTH_DT»

Drug Utilization Evaluation Program: Opioid Overutilization

Your feedback is essential for this drug utilization review

Please mark all applicable statements:

- ❑ Patient is **NOT** at-risk for drug abuse or misuse. The drug therapy is appropriate, medically necessary, and safe for treatment of (please check all that apply):
  - ❑ Cancer ❑ Sickle Cell Disease ❑ Severe pain due to _____
  - ❑ Post-surgery ❑ Other: _____
- ❑ Patient is currently in hospice, receiving palliative care, or residing in a long-term care facility.
- ❑ I am aware of the patient's history of opioid-related overdose with prescription opioid use and will manage/coordinate the beneficiary's FAD (frequently abused drug) use.
- ❑ This is **NOT my patient**. My records show this patient's primary care provider is *(please list if known)* _____
- ❑ I did **NOT** prescribe the following medication(s) associated with my DEA or NPI number. *(If the wrong physician's name, DEA or NPI number is linked to the prescription at the pharmacy, the patient may have been improperly identified as yours.)* My records show this patient's primary care provider is *(please list if known)*: _____
- ❑ Patient **IS** at-risk for drug abuse or misuse.
  - **Note**: If you indicate the patient **IS** at-risk, the medication management pharmacist will call you to discuss the possibility to restrict the member to a specific prescriber and/or pharmacy or limit the quantity or type of opioid medication your patient can receive through their Medicare drug coverage.
- ❑ I would like to discuss this profile with the medication management pharmacist. (*Please include the best contact name and number for your office.)* _____

Questions or comments: _____

Kern Family Health Care®
Medicare (D-SNP)

Signature: _____ Date: _____

Member Name: «MEMBER_FULL_NAME» Member #: «MEMBER_NO» Birth Date: «BIRTH_DT»

Average MED: «AVG_MME» Plan Sponsor: «CARRIER_HQ_NAME»

Fill Date	Brand/Strength	Dosage Form	Qty	Days Supply	Provider
«FILL_DT1»	«BRAND_STRENGTH1»	«DOSAGE_FORM1»	«QTY_SUPPLY1»	«DAYS_SUPPLY1»	«PHYSICIAN_FULL_NAME_CLAIM1»
«FILL_DT2»	«BRAND_STRENGTH2»	«DOSAGE_FORM2»	«QTY_SUPPLY2»	«DAYS_SUPPLY2»	«PHYSICIAN_FULL_NAME_CLAIM2»
«FILL_DT3»	«BRAND_STRENGTH3»	«DOSAGE_FORM3»	«QTY_SUPPLY3»	«DAYS_SUPPLY3»	«PHYSICIAN_FULL_NAME_CLAIM3»
«FILL_DT4»	«BRAND_STRENGTH4»	«DOSAGE_FORM4»	«QTY_SUPPLY4»	«DAYS_SUPPLY4»	«PHYSICIAN_FULL_NAME_CLAIM4»
«FILL_DT5»	«BRAND_STRENGTH5»	«DOSAGE_FORM5»	«QTY_SUPPLY5»	«DAYS_SUPPLY5»	«PHYSICIAN_FULL_NAME_CLAIM5»
«FILL_DT6»	«BRAND_STRENGTH6»	«DOSAGE_FORM6»	«QTY_SUPPLY6»	«DAYS_SUPPLY6»	«PHYSICIAN_FULL_NAME_CLAIM6»
«FILL_DT7»	«BRAND_STRENGTH7»	«DOSAGE_FORM7»	«QTY_SUPPLY7»	«DAYS_SUPPLY7»	«PHYSICIAN_FULL_NAME_CLAIM7»
«FILL_DT8»	«BRAND_STRENGTH8»	«DOSAGE_FORM8»	«QTY_SUPPLY8»	«DAYS_SUPPLY8»	«PHYSICIAN_FULL_NAME_CLAIM8»
«FILL_DT9»	«BRAND_STRENGTH9»	«DOSAGE_FORM9»	«QTY_SUPPLY9»	«DAYS_SUPPLY9»	«PHYSICIAN_FULL_NAME_CLAIM9»
«FILL_DT10»	«BRAND_STRENGTH10»	«DOSAGE_FORM10»	«QTY_SUPPLY10»	«DAYS_SUPPLY10»	«PHYSICIAN_FULL_NAME_CLAIM10»
«FILL_DT11»	«BRAND_STRENGTH11»	«DOSAGE_FORM11»	«QTY_SUPPLY11»	«DAYS_SUPPLY11»	«PHYSICIAN_FULL_NAME_CLAIM11»
«FILL_DT12»	«BRAND_STRENGTH12»	«DOSAGE_FORM12»	«QTY_SUPPLY12»	«DAYS_SUPPLY12»	«PHYSICIAN_FULL_NAME_CLAIM12»
«FILL_DT13»	«BRAND_STRENGTH13»	«DOSAGE_FORM13»	«QTY_SUPPLY13»	«DAYS_SUPPLY13»	«PHYSICIAN_FULL_NAME_CLAIM13»
«FILL_DT14»	«BRAND_STRENGTH14»	«DOSAGE_FORM14»	«QTY_SUPPLY14»	«DAYS_SUPPLY14»	«PHYSICIAN_FULL_NAME_CLAIM14»
«FILL_DT15»	«BRAND_STRENGTH15»	«DOSAGE_FORM15»	«QTY_SUPPLY15»	«DAYS_SUPPLY15»	«PHYSICIAN_FULL_NAME_CLAIM15»
«FILL_DT16»	«BRAND_STRENGTH16»	«DOSAGE_FORM16»	«QTY_SUPPLY16»	«DAYS_SUPPLY16»	«PHYSICIAN_FULL_NAME_CLAIM16»

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Medicare (D-SNP)

«FILL_DT17»	«BRAND_STRENGTH17»	«DOSAGE_FORM17»	«QTY_SUPPLY17»	«DAYS_SUPPLY17»	«PHYSICIAN_FULL_NAME_CLAIM17»
«FILL_DT18»	«BRAND_STRENGTH18»	«DOSAGE_FORM18»	«QTY_SUPPLY18»	«DAYS_SUPPLY18»	«PHYSICIAN_FULL_NAME_CLAIM18»
«FILL_DT19»	«BRAND_STRENGTH19»	«DOSAGE_FORM19»	«QTY_SUPPLY19»	«DAYS_SUPPLY19»	«PHYSICIAN_FULL_NAME_CLAIM19»
«FILL_DT20»	«BRAND_STRENGTH20»	«DOSAGE_FORM20»	«QTY_SUPPLY20»	«DAYS_SUPPLY20»	«PHYSICIAN_FULL_NAME_CLAIM20»

Kern Family Health Care®
Medicare (D-SNP)

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

Phone: <PRESCRIBER PHONE>
Fax: <PRESCRIBER FAX>

<DATE>

RE: <MEMBER NAME>
<MEMBER DOB>
<Member ID>

Dear <PRESCRIBER NAME>:

Recently, the Drug Management Program at Kern Family Health Care Medicare (HMO D-SNP) communicated with you regarding the opioid utilization review for your patient, <MEMBER NAME>. Based on your input, it was determined that your patient is at-risk for abuse or misuse of frequently abused drugs (FADs), and that a coverage limitation on opioids and/or benzodiazepines is deemed necessary. Specifically, it was agreed that your patient should have a prescriber limitation implemented.

We are contacting you today to provide confirmation that you will serve as the patient's selected prescriber for [select one: <opioids> or <benzodiazepines> or <opioids and benzodiazepines>]. This means that any prescription claims for your patient for [select one: <opioids> or <benzodiazepines> or <opioids and benzodiazepines>] must be prescribed by you to be covered by our plan.

If you have any questions or concerns with this letter, or if you would like any further information about your patient's opioid prescriptions in the future for your treatment purposes, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm Pacific Standard Time.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Kern Family Health Care
Medicare (D-SNP)

March 16, 2026

«PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
«PHYSICIAN_ADDR_LINE_1»
«PHYSICIAN_ADDR_LINE_2»
«PHYSICIAN_CITY», «PHYSICIAN_STATE_CD» «PHYSICIAN_ZIP_CD»

RE: MEMBER_ID: «MEMBER_NO»

Dear Provider:

Kern Family Health Care Medicare (HMO D-SNP) is sending you this letter to request your assistance and response. Our Drug Management Program has determined that a patient under your care is being prescribed a certain dosage of an opioid medication(s) and/or has opioid prescriptions involving multiple prescribers and/or pharmacies. In addition, your patient has also utilized a benzodiazepine and/or gabapentinoid concurrently with an opioid medication.

The Centers for Medicare & Medicaid Services (CMS) encourages a drug utilization review when patients receiving opioid prescriptions from seven (7) or more providers or pharmacies are identified. This review also includes the patient's concurrent use of opioids with benzodiazepines, gabapentin (in daily doses exceeding 2,400mg/day) or pregabalin. The combination of opioids and benzodiazepines can cause extreme sleepiness and exacerbate respiratory depression, the primary factor in fatal opioid overdose. The risk of opioid-related morbidity and mortality is increased in all patients, even those who do not show signs of aberrant drug behavior. Furthermore, the Centers for Disease Control (CDC) advises clinicians to avoid prescribing opioids and benzodiazepines concurrently whenever possible.[1] In addition, gabapentinoids have been identified as potentiator drugs that may pose safety risks when misused with opioids. They have also been identified as an independent risk factor for opioid-related deaths and is reportedly misused due to the euphoria associated with use at high doses.

Attached is a list of opioid pain medications, benzodiazepines, and/or gabapentinoids prescribed for your patient, which includes all medications of which we are aware, the dosage(s) prescribed, and the time period we are reviewing.

We ask that you complete the attached questionnaire to confirm that the opioid medication(s) and current cumulative opioid dosages being prescribed for your patient are appropriate, medically necessary, and safe. Also, please provide the current treatment plan for your patient's concurrent opioid, benzodiazepine, and/or gabapentinoid therapy, as indicated. **Please respond by filling out the following page and faxing it back to us at (844) 713-1304.**

We thank you for your assistance in addressing this matter. We urge you to be responsive as your input is imperative. Should you have any questions, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm, Pacific Standard Time, and please refer to the Member ID above.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)
Attachments

[1] http://www.cdc.gov/drugoverdose/prescribing/guideline.html

Kern Family Health Care
Medicare (D-SNP)

Please fax this form back to us at (844) 713-1304

March 16, 2026

Provider Name: «PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
Provider Phone: «PHYSICIAN_PHONE»
Provider FAX: «PHYSICIAN_FAX»

RE: Member: «MEMBER_FULL_NAME»
Member ID: «MEMBER_NO»
DOB: «BIRTH_DT»

Drug Utilization Evaluation Program: Opioid Overutilization

Your feedback is essential for this drug utilization review.

Please provide details of patient's opioid drug therapy: *Select all statements that apply*

- ❑ Patient is **NOT** at-risk for prescription drug abuse or misuse. The opioid drug therapy is appropriate, medically necessary, and safe for the treatment of (*please check all that apply*):
  - ❑ Cancer ❑ Sickle Cell Disease ❑ Severe pain due to _____
  - ❑ Post-surgery ❑ Other: _____
- ❑ Patient is in hospice, receiving palliative care, or is residing in a long-term care facility.
- ❑ I am aware of the patient's opioid and benzodiazepine and/or gabapentinoid use and will manage/coordinate the beneficiary's FAD (frequently abused drug) use.
- ❑ This is **NOT my patient**. My records show this patient's primary care provider is *(please list if known)* _____
- ❑ I did **NOT** prescribe the following medication(s) associated with my DEA or NPI number. *(If the wrong physician's name, DEA or NPI number is linked to the prescription at the pharmacy, the patient may have been improperly identified as yours.)* My records show this patient's primary care provider is *(please list if known):* _____ _____
- ❑ Patient **IS** at-risk for prescription drug abuse or misuse. **Note**: If you indicate the patient **IS** at-risk, the medication management pharmacist will call you to discuss the possibility to restrict the member to a specific prescriber and/or pharmacy or limit the quantity or type of opioid medication your patient can receive through their Medicare drug coverage.

Please provide details of patient's benzodiazepine drug therapy (if applicable):

- ❑ The concurrent use of benzodiazepines with opioids is medically necessary due to (*please include diagnosis*): _____
- ❑ Benzodiazepine therapy will be:
  - ❑ Tapered ❑ Discontinued ❑ Changed to:_____

Please provide details of patient's pregabalin or gabapentin drug therapy (if applicable):

- ❑ The concurrent use of pregabalin or gabapentin with opioids is medically necessary due to (*please include diagnosis*): _____
- ❑ Pregabalin or gabapentin therapy will be:
  - ❑ Tapered ❑ Discontinued ❑ Changed to:_____

- ❑ I would like to discuss this profile with the medication management pharmacist. *(Please include the best contact name and number for your office)*. _____

Kern Family Health Care®
Medicare (D-SNP)

Questions or comments: _____

Signature: _____ Date: _____

Kern Family Health Care
Medicare (D-SNP)

Member Name: «MEMBER_FULL_NAME» Member #: «MEMBER_NO» Birth Date: «BIRTH_DT»
Average MME: «AVG_MME» Plan Sponsor: «CARRIER_HQ_NAME»

Fill Date	Brand/Strength	Dosage Form	Qty	Days Supply	Provider
«FILL_DT1»	«BRAND_STRENGTH1»	«DOSAGE_FORM1»	«QTY_SUPPLY1»	«DAYS_SUPPLY1»	«PHYSICIAN_FULL_NAME_CLAIM1»
«FILL_DT2»	«BRAND_STRENGTH2»	«DOSAGE_FORM2»	«QTY_SUPPLY2»	«DAYS_SUPPLY2»	«PHYSICIAN_FULL_NAME_CLAIM2»
«FILL_DT3»	«BRAND_STRENGTH3»	«DOSAGE_FORM3»	«QTY_SUPPLY3»	«DAYS_SUPPLY3»	«PHYSICIAN_FULL_NAME_CLAIM3»
«FILL_DT4»	«BRAND_STRENGTH4»	«DOSAGE_FORM4»	«QTY_SUPPLY4»	«DAYS_SUPPLY4»	«PHYSICIAN_FULL_NAME_CLAIM4»
«FILL_DT5»	«BRAND_STRENGTH5»	«DOSAGE_FORM5»	«QTY_SUPPLY5»	«DAYS_SUPPLY5»	«PHYSICIAN_FULL_NAME_CLAIM5»
«FILL_DT6»	«BRAND_STRENGTH6»	«DOSAGE_FORM6»	«QTY_SUPPLY6»	«DAYS_SUPPLY6»	«PHYSICIAN_FULL_NAME_CLAIM6»
«FILL_DT7»	«BRAND_STRENGTH7»	«DOSAGE_FORM7»	«QTY_SUPPLY7»	«DAYS_SUPPLY7»	«PHYSICIAN_FULL_NAME_CLAIM7»
«FILL_DT8»	«BRAND_STRENGTH8»	«DOSAGE_FORM8»	«QTY_SUPPLY8»	«DAYS_SUPPLY8»	«PHYSICIAN_FULL_NAME_CLAIM8»
«FILL_DT9»	«BRAND_STRENGTH9»	«DOSAGE_FORM9»	«QTY_SUPPLY9»	«DAYS_SUPPLY9»	«PHYSICIAN_FULL_NAME_CLAIM9»
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«FILL_DT11»	«BRAND_STRENGTH11»	«DOSAGE_FORM11»	«QTY_SUPPLY11»	«DAYS_SUPPLY11»	«PHYSICIAN_FULL_NAME_CLAIM11»
«FILL_DT12»	«BRAND_STRENGTH12»	«DOSAGE_FORM12»	«QTY_SUPPLY12»	«DAYS_SUPPLY12»	«PHYSICIAN_FULL_NAME_CLAIM12»
«FILL_DT13»	«BRAND_STRENGTH13»	«DOSAGE_FORM13»	«QTY_SUPPLY13»	«DAYS_SUPPLY13»	«PHYSICIAN_FULL_NAME_CLAIM13»
«FILL_DT14»	«BRAND_STRENGTH14»	«DOSAGE_FORM14»	«QTY_SUPPLY14»	«DAYS_SUPPLY14»	«PHYSICIAN_FULL_NAME_CLAIM14»
«FILL_DT15»	«BRAND_STRENGTH15»	«DOSAGE_FORM15»	«QTY_SUPPLY15»	«DAYS_SUPPLY15»	«PHYSICIAN_FULL_NAME_CLAIM15»
«FILL_DT16»	«BRAND_STRENGTH16»	«DOSAGE_FORM16»	«QTY_SUPPLY16»	«DAYS_SUPPLY16»	«PHYSICIAN_FULL_NAME_CLAIM16»

Kern Family Health Care
Medicare (D-SNP)

«FILL_DT17»	«BRAND_STRENGTH17»	«DOSAGE_FORM17»	«QTY_SUPPLY17»	«DAYS_SUPPLY17»	«PHYSICIAN_FULL_NAME_CLAIM17»
«FILL_DT18»	«BRAND_STRENGTH18»	«DOSAGE_FORM18»	«QTY_SUPPLY18»	«DAYS_SUPPLY18»	«PHYSICIAN_FULL_NAME_CLAIM18»
«FILL_DT19»	«BRAND_STRENGTH19»	«DOSAGE_FORM19»	«QTY_SUPPLY19»	«DAYS_SUPPLY19»	«PHYSICIAN_FULL_NAME_CLAIM19»
«FILL_DT20»	«BRAND_STRENGTH20»	«DOSAGE_FORM20»	«QTY_SUPPLY20»	«DAYS_SUPPLY20»	«PHYSICIAN_FULL_NAME_CLAIM20»
«FILL_DT21»	«BRAND_STRENGTH21»	«DOSAGE_FORM21»	«QTY_SUPPLY21»	«DAYS_SUPPLY21»	«PHYSICIAN_FULL_NAME_CLAIM21»
«FILL_DT22»	«BRAND_STRENGTH22»	«DOSAGE_FORM22»	«QTY_SUPPLY22»	«DAYS_SUPPLY22»	«PHYSICIAN_FULL_NAME_CLAIM22»
«FILL_DT23»	«BRAND_STRENGTH23»	«DOSAGE_FORM23»	«QTY_SUPPLY23»	«DAYS_SUPPLY23»	«PHYSICIAN_FULL_NAME_CLAIM23»
«FILL_DT24»	«BRAND_STRENGTH24»	«DOSAGE_FORM24»	«QTY_SUPPLY24»	«DAYS_SUPPLY24»	«PHYSICIAN_FULL_NAME_CLAIM24»
«FILL_DT25»	«BRAND_STRENGTH25»	«DOSAGE_FORM25»	«QTY_SUPPLY25»	«DAYS_SUPPLY25»	«PHYSICIAN_FULL_NAME_CLAIM25»
«FILL_DT26»	«BRAND_STRENGTH26»	«DOSAGE_FORM26»	«QTY_SUPPLY26»	«DAYS_SUPPLY26»	«PHYSICIAN_FULL_NAME_CLAIM26»

Kern Family Health Care
Medicare (D-SNP)

March 16, 2026

«PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»
«PHYSICIAN_ADDR_LINE_1»
«PHYSICIAN_ADDR_LINE_2»
«PHYSICIAN_CITY», «PHYSICIAN_STATE_CD» «PHYSICIAN_ZIP_CD»

RE: MEMBER_ID: «MEMBER_NO»

Dear Provider:

Kern Family Health Care Medicare (HMO D-SNP) is sending you this letter to request your assistance and response. Our Drug Management Program has determined that one of your patients is being prescribed a certain dosage of an opioid medication(s) and/or has opioid prescriptions involving multiple prescribers and/or pharmacies. Please review the attached list of medication(s) prescribed for your patient, which includes all opioid medications of which we are aware, the dosage(s) prescribed, and the time period we are reviewing.

Centers for Medicare and Medicaid Services (CMS) encourages a utilization review when patients receiving opioid prescriptions from seven (7) or more providers or pharmacies are identified. We ask that you complete the attached brief questionnaire to confirm that the opioid medication(s) and current cumulative opioid dosages being prescribed for your patient are appropriate, medically necessary, and safe. **Please respond by filling out the following page and faxing it back to us at (844) 713-1304.** Also included are options you can elect to help in the management of your patient. These options include referral to a pain clinic, locking the member to a specific prescriber and/or pharmacy, and/or placing restrictions on the amount or type of opioid medication your patient can receive through their Medicare drug coverage.

We thank you for your assistance in addressing this matter and urge you to be responsive. If we are unable to establish that the current dosage of opioid medication(s) is appropriate, medically necessary, and safe, we may be required to restrict the beneficiary's coverage of some or all of these medications.

Should you have any questions, please contact our Medication Management Pharmacist, Nilo Young, at 858-291-5368 during the hours of 9am to 5pm, Pacific Standard Time, and please refer to the Member ID above.

Sincerely,

Kern Family Health Care Medicare (HMO D-SNP)

Attachments

Kern Family Health Care
Medicare (D-SNP)

Please fax this form back to us at (844) 713-1304

March 16, 2026

Provider Name: «PHYSICIAN_FIRST_NAME» «PHYSICIAN_LAST_NAME»

Provider Phone: «PHYSICIAN_PHONE»

Provider Fax: «PHYSICIAN_FAX»

RE: Member: «MEMBER_FULL_NAME»
Member ID: «MEMBER_NO»
DOB: «BIRTH_DT»

Drug Utilization Evaluation Program: Opioid Overutilization

Your feedback is essential for this drug utilization review

Please mark all applicable statements:

- ❑ Patient is **NOT** at-risk for drug abuse or misuse. The drug therapy is appropriate, medically necessary, and safe for treatment of (*please check all that apply*):
  - ❑ Cancer ❑ Sickle Cell Disease ❑ Severe pain due to _____
  - ❑ Post-surgery ❑ Other: _____
- ❑ Patient is currently in hospice, receiving palliative care, or residing in a long-term care facility.
- ❑ I am aware of the patient's opioid use and will manage/coordinate the beneficiary's FAD (frequently abused drug) use.
- ❑ This is **NOT my patient**. My records show this patient's primary care provider is *(please list if known)* _____
- ❑ I did **NOT** prescribe the following medication(s) associated with my DEA or NPI number. *(If the wrong physician's name, DEA or NPI number is linked to the prescription at the pharmacy, the patient may have been improperly identified as yours.)* My records show this patient's primary care provider is *(please list if known)*: _____
- ❑ Patient **IS** at-risk for drug abuse or misuse.
  - **Note**: If you indicate the patient **IS** at-risk, the medication management pharmacist will call you to discuss the possibility to restrict the member to a specific prescriber and/or pharmacy or limit the quantity or type of opioid medication your patient can receive through their Medicare drug coverage.
- ❑ I would like to discuss this profile with the medication management pharmacist. *(Please include the best contact name and number for your office).* _____

Kern Family Health Care®
Medicare (D-SNP)

Questions or comments: _____

Signature: _____ Date: _____

Kern Family Health Care®
Medicare (D-SNP)

Member Name: «MEMBER_FULL_NAME» Member #: «MEMBER_NO» Birth Date: «BIRTH_DT»
Average MED: «AVG_MME» Plan Sponsor: «CARRIER_HQ_NAME»

Fill Date	Brand/Strength	Dosage Form	Qty	Days Supply	Provider
«FILL_DT1»	«BRAND_STRENGTH1»	«DOSAGE_FORM1»	«QTY_SUPPLY1»	«DAYS_SUPPLY1»	«PHYSICIAN_FULL_NAME_CLAIM1»
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Kern Family Health Care®
Medicare (D-SNP)

«FILL_DT17»	«BRAND_STRENGTH17»	«DOSAGE_FORM17»	«QTY_SUPPLY17»	«DAYS_SUPPLY17»	«PHYSICIAN_FULL_NAME_CLAIM17»
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«FILL_DT19»	«BRAND_STRENGTH19»	«DOSAGE_FORM19»	«QTY_SUPPLY19»	«DAYS_SUPPLY19»	«PHYSICIAN_FULL_NAME_CLAIM19»
«FILL_DT20»	«BRAND_STRENGTH20»	«DOSAGE_FORM20»	«QTY_SUPPLY20»	«DAYS_SUPPLY20»	«PHYSICIAN_FULL_NAME_CLAIM20»