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**An important message about your
<<client name>>
prescription drug benefit**

<<Patient Name Prefix>> <<Patient First Name>> <<Patient Last Name>>
<<Street Address>>
<<City>> <<State>> <<Zip>>

<<Month/Year>>

<<key code>>

Dear <<Patient Name Prefix>> <<Patient First Name>> <<Patient Last Name>>:

We are writing to provide you with important information about the medication (or medications) listed in the chart on the back of this letter. If you are taking any of these medications, please note the following information.

Beginning <<DATE>>, prescriptions for these medications can be filled under your plan up to the quantities indicated. These quantities are based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective.

For certain medications (as indicated on the chart), your doctor may request a review for approval of additional quantities. As part of this review, your doctor will need to provide more information than what is on the prescription.

To arrange a review, please ask your doctor to call Express Scripts toll-free at 1 800 417-1764, 8:00 a.m. to 9:00 p.m., eastern time, Monday through Friday. **Unless your doctor obtains approval, you will be responsible for the cost of the medication that exceeds the quantity indicated on the chart.**

Thank you for your attention to this very important matter. Please disregard this letter if you are no longer eligible under this plan or if you are not taking this medication.

Sincerely,

<<signature id 1>>

<<signature id 2>>

LT900630

<<Mailing Control ID>>
<<Letter ID>>

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