



COLORADO
Department of Health Care
Policy & Financing
Pharmacy Unit
1570 Grant Street
Denver, CO 80203

[Date]

[Provider Name]

[Address]

[City, State Zip]

RE: [Patient Name]

DOB:

State ID: [X123456]

Dear Dr. [Provider Name]:

I am a pharmacist licensed in the State of Colorado participating in the Rx Review Program through the Department of Health Care Policy and Financing (the Department). This program provides medication therapy counseling for Medicaid clients who are on five or more drugs for three months in a row. The Department has contracted with me to provide a comprehensive medication evaluation. This includes a review of all prescription medications, as well as OTC's and nutritional supplements designed to identify and reduce/eliminate negative interactions and duplicate therapies.

On [Date], I visited with [Patient Name] (current medications are attached). After reviewing the patient's medication profile, I have the following recommendations for maximizing the drug therapy benefit:

[SPECIFIC, YET SUCCINCT RECOMMENDATIONS (see Pharmacist Orientation and Instructions for an example)]

These recommendations are based on the information provided by your patient; but have been made without access to their full medical record. Any decisions regarding changes in this patient's drug management program will be entirely dependent upon mutual agreement between you and your patient. Thank you for making every attempt to adhere to the current Colorado Medicaid Preferred Drug List (PDL). Following the PDL will save you time and will expedite the patient obtaining their prescription from the pharmacy. The current PDL is located at www.colorado.gov/hcpf → For Our Providers → Provider Services (training, & more) → Forms → Pharmacy → Preferred Drug List.

Please feel free to contact me if you have any questions or concerns regarding these recommendations. Please direct program questions to the Rx Review Coordinator, Sara Haynes, at 303-866-4229 or via email at sara.haynes@state.co.us.

The patient and the patient's other providers (if any) have been also notified of these recommendations.



Regards,

[Pharmacist Name, Title]

[Address]

[City, State Zip]

[Phone]

[Email Address]

cc: Rx Review Coordinator, Department of Health Care Policy and Financing
[Patient Name]
[Provider Name]
[Provider Name]