

Facsimile Cover Sheet Total pages: 2

Patient Prescription Change Request

To: Sample Prescriber Name

Fax: 888888888

Sample Prescriber Name,

My health plan provides Rx Savings Solutions as a benefit that helps identify lower-cost options for my medications. I'm asking for your help in evaluating and approving the suggested lower-cost alternative(s) identified in this message. Making the switch to this lower cost prescription will help me save \$25.0 per fill.

You will see the specifics of the request on the next page. If you approve my request, please fax or eprescribe the new prescription to the requested pharmacy. For any questions, please call **Rx Savings Solutions** at **1-800-268-4476**.

Thank you for your help,

Keerti Test Contact

CONFIDENTIALITY NOTICE: The information contained in this facsimile message is privileged, confidential information subject to protection under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended for the use of the individual or entity named above. If you are not the intended recipient you are hereby notified that any disclosure, copying, or distribution of this information is STRICTLY prohibited. Protected Health Information is personal and sensitive and should only be read by authorized individuals. Please be advised that the recipient is expected to maintain this information in a safe, secure and confidential manner. HIPAA prohibits further disclosure except with specific written consent of the person to whom the information pertains. Failure to maintain confidentiality is subject to penalties under state and federal law.

Rx Savings Solutions is an independent company that helps Blue Advantage (PPO) plan members find lower price options for prescription medications.

Blue Advantage® PPO is provided by Patrius Health, an independent licensee of the Blue Cross and Blue Shield Association.



Patient Prescription Change Request

Sample Suggested Pharmacy Address Sample Suggested

Pharmacy City, Sample Suggested Pharmacy State 12345

Your patient is requesting to lower the cost of their medications by switching to a new prescription. Please sign and fax or e-prescribe the new prescription to the pharmacy below once approved.

once approved	<u>d.</u>					
Patient Name: Patient Address	DOB:	Phone:				
Patient Savings:	\$25.0 per fill		Payer Savings:	\$50.0 per fill		
STEP 1: Sar refills.	mple Prescr	iber Name co	omplete order v	vith directions	, signature a	nd
Current Mood medication	name # 20.0					
Medication		Strength	SIG	Qty.	# of Refills	DAW
Sample Medic Name Sample Medic Name Sample Medic Name	ation 2	50mg Tablet 50mg Tablet gel	310	1 1 5	# Of Refills	DAW
Physician addres	·	-	/sician contact : Sa Sample Prescriber (•		1 5
NPI:	ON PERMITT				AS WRITTEN	_
STEP 2: Whe	en approved	, send compl	leted order to:			
Fax: 191335982 e-Prescribe to ph CVS Pharmacy (narmacy			If Denied: Check here and FAX denial to (800) 886-4654 or call (800) 268-4476		

to reach Rx Savings Solutions

Pharmacy Support.