

*Proudly representing retirees of the AT&T Midwest Region, SBC Midwest Region, Ameritech, and predecessor/successor Bell Companies of the New AT&T, located throughout the United States*

AT&T has replied to our questions concerning Caremark processes that some of our members felt might be an infringement on our privacy and our management of healthcare and medical costs. We are satisfied with their responses. A synopsis follows:

**Caremark on occasion directly contacts a member's physician to change prescriptions to use a generic drug without involving the plan participant which seems to be a possible violation of HIPPA laws. Is this correct?**

*There is no HIPAA violation. 45 Code of Federal Regulations section 164.506 of HIPAA regulations permit one health care provider to discuss patient treatment, including alternative medicines, with another health care provider without authorization from the patient.*

*Caremark communicates directly with the Prescriber who reviews and approves each change. This communication is clinician-to-clinician. It is guided by the standards of professional practice with the intent on improving clinical appropriateness for each therapy.*

**Generics may have already been tried without success.**

*If generics had been tried without success then the provider/provider's office should deny the switch. If the member desires not to take generics, or a specific generic, they should have that discussion with the provider during the office visit at the time the drug is being prescribed, so the member's file can be noted and the prescription written out as "Dispense as Written". Caremark can not make a switch from brand to generic with "Dispense as Written", without gaining approval from the provider/provider's office. If the provider has noted the file, then the switch should not be made.*

**The patient is paying for the drug so should have the right to decide if he wants a generic or not. Caremark is not affording them this opportunity. Is there an objective or a cost consideration to AT&T for the number of generic substitutions?**

*On Page 83 of the AT&T Medical Plan SPD it states:*

*"Generic Drugs*

*Your Prescription Drug Claims Administrator promotes the use of Generic Drug equivalents whenever possible. Your Prescription Drug Claims Administrator may fill your prescription with A Generic Drug if the prescription is not marked "Dispense as Written." Even if the prescription contains this stipulation, a change to a generic Drug equivalent may be made if your Prescription Drug Claims Administrator's pharmacist contacts your Physician and obtains his or her consent, either written or verbal. If the Physician does not approve the change, your prescription will be filled as originally written."*

*Overall the cost of generics is less expensive to the member as well as the plan, the AT&T Medical Plan encourages the use of generics, through the copay structure.*

**Changing the number of refills forces the patient to schedule unnecessary office visits at an additional cost to the patient.**

*While this may be true in certain instances, Caremark's safety and utilization review at mail targets specific drugs and drug classes commonly prone to inefficient and inappropriate utilization and prescribing. The prescription order is reviewed at mail via an edit system then a clinician reviews the case and makes appropriate suggestions to the prescriber. Edits are based on clinical literature and updated on a regular basis. All edits are reviewed annually by non-Caremark physicians for clinical appropriateness.*

Although we, individually, may not agree with Caremark contacting our doctor and getting agreement to change our prescription without us being involved, we must remember that we are still in control of our care. We, as patients and medical care consumers, can talk with our doctors and insist that they do not change medications or time frames without consulting with us, their patients. We, the patients, should remain in control as we certainly are.