

**Attachment 3: WISCONSIN RETROSPECTIVE DRUG UTILIZATION REVIEW
ANTICHOLINERGIC BURDEN DRUG INTERVENTION**

All information used to generate the enclosed letter, including Prescriber Identification, was obtained from Medicaid paid claims data submitted by pharmacies. If there appears to be an error in the information provided, please note the discrepancy. Thank you for your cooperation.

PRESCRIBER RESPONSE

I have reviewed the information provided and found it:

- very useful.
- useful.
- neutral.
- minimally useful.
- not useful.

I have reviewed the information provided and:

- discontinued the medication(s). List _____
- will review the treatment regimens for my patients.
- have already explored other options before prescribing these drugs.
- modified how I am prescribing anticholinergic drugs.
- did not modify the drug therapy because I believe treatment is appropriate.
- did not change therapy because benefits outweigh risks.
- tried to modify the drug therapy, however, the patient refuses to change medications.
- am aware that the patient is taking these drugs and am monitoring for adverse reactions.

The individual has the following diagnoses/conditions that require anticholinergic drugs:

Additional Comments: _____

Please return response form to:
APS Healthcare
10 East Doty Street, Suite 210
Madison, WI 53703