Pharmacy Provider Reconsideration Request Form

Please fax form to 503-416-1428

Information required for processing this request:

- All fields must be completed and the information must be legible.
- Provide documentation supporting your statement (e.g. medical records and clinical studies.)
- Provide a statement of why you disagree with the original denial reason and/or why you disagree with the criteria we used to make the original decision.

Determinations for Oregon Health Plan members will be rendered within 16 days from the date received. For assistance with this form call CareOregon at 503-416-4100 from 8 a.m. to 5 p.m., Monday through Friday.

Note: Provider Reconsideration Request must be received within 60 days from the date of the original denial of the medication.

Patient Information

Patient Name: _____

Member ID: _____

Date of Birth: _____

Patient Phone: _____

Prescriber Information

Prescriber Name: _____

Office Phone: _____

Office Fax: _____

Contact Person: _____

Medication Information

Medication: _____ Date of Denial: _____

Additional Diagnosis Code(s) (ICD-10): _____

Reason Given for Original Denial (check all that apply):

☐ Age or Quantity Limit Exceeded ☐ Below the Line Diagnosis ☐ Does Not Meet PA Criteria

☐ Experimental/Investigational Use ☐ Insufficient Information ☐ Non-Formulary ☐ Other

Rationale For Request

Provide a statement that explains why you disagree with the original denial or with the criteria we used in our determination. Please provide documentation supporting your statement (e.g. medical records and clinical studies).

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Prescriber's Signature: _____ **Date:** _____

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