

# 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	Prescriber Information
Patient Name: _____	Prescriber Name: _____
Member ID: _____	Office Phone: _____
Date of Birth: _____	Office Fax: _____
Patient Phone: _____	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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<b>Prescriber's Signature:</b> _____	<b>Date:</b> _____
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