9958

Texas Vendor Drug Program

Prior Authorization Request for Reconsideration

Request Date ☐☐ / ☐☐ / ☐☐☐☐

The prescriber may request reconsideration of a drug prior authorization denial by completing the information on this form. **Please provide copies of the patient's medical records and/or lab results in addition to any supporting peer-reviewed literature to assist in evaluating the therapy.** The request will be evaluated by a healthcare professional and you will be notified in writing, of the prior authorization decision within 5 business days.

PATIENT INFORMATION

Patient's Medicaid ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State ☐☐ Zip Code ☐☐☐☐☐ - ☐☐☐☐

Prescriber Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber TX License #

Drug Requested:

Strength (mg's) ☐☐ Quantity ☐☐ Length of Therapy on Prescription ☐☐ Months Frequency of Dosing _____

Please include supporting medical documentation from the patient's records and/or lab results to assist in evaluating the requested therapy. DOCUMENTATION SUPPORTING DIAGNOSIS INCLUDED: O Yes O No

DIAGNOSIS: _____

Signature of Prescriber _____ Date ☐☐ / ☐☐ / ☐☐☐☐

By signature, the Prescriber confirms the information provided is accurate.

FAX TO: Texas Prior Authorization Center
Fax: (866)-617-8864

PA HELPDESK: (866)-855-8430
Hours: Monday - Friday 7:30 am- 6:30 pm CST

9958

ev.Date 08/16/2005