Rev. Date 01/23/11

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
MEDICAID 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: ◯ **Yes** ◯ **No**

Diagnosis:

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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 Help Desk: (877) PA-TEXAS (877) 728-3927
Hours: Monday–Friday 7:30 am–6:30 pm CST