



**Phone: 1-877-537-0722**  
**FAX TO: 1-877-537-0720**

Division of Medicaid  
Pharmacy Prior Authorization Unit  
550 High St  
Suite 1000  
Jackson, MS 39201

**PHARMACY APPEAL/ RECONSIDERATION**  
**PRIOR AUTHORIZATION REQUEST FORM**

**BENEFICIARY INFORMATION**

Beneficiary's Name: \_\_\_\_\_ Beneficiary's Medicaid: \_\_\_\_\_

DOB: \_\_\_\_\_ City: \_\_\_\_\_  
Month/ Day/ 4-Digit Year

**PRESCRIBER INFORMATION**

Prescribing Physician: \_\_\_\_\_ NPI #: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_ Phone #: \_\_\_\_\_ FAX: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

\_\_\_\_\_  
Physician's signature and date

*I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.*

**PHARMACY INFORMATION**

Dispensing Pharmacy: \_\_\_\_\_ Provider #: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Strength: \_\_\_\_\_

Reference PA #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone #: \_\_\_\_\_ FAX: \_\_\_\_\_

**REQUEST INFORMATION**

Date of Request: \_\_\_\_\_ Requested By: Physician      Beneficiary

Date of Denial Notification: \_\_\_\_\_

\*Requester is encouraged to submit any additional information to support the request for appeal

**RATIONALE/ MEDICAL REASON FOR DISAGREEMENT**

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