

# PHARMACY RECONSIDERATION REQUEST FORM

GAINWELL TECHNOLOGIES - MS PRIOR AUTHORIZATION DIVISION  
PO Box 2480, Ridgeland, MS 39158



Fax to: 1-866-644-6147 Ph: 1-833-660-2402

<https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/>

BENEFICIARY INFORMATION	
Beneficiary ID: _____ - _____ - _____	DOB: ____/____/____
Beneficiary Full Name: _____	
PRESCRIBER INFORMATION	
Prescriber's NPI: _____	
Prescriber's Full Name: _____	Phone: _____
Prescriber's Address: _____	FAX: _____
RECONSIDERATION REQUEST	
<ul style="list-style-type: none"><li>• MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.</li><li>• If you have submitted a prior authorization that has been denied, you may submit a reconsideration form.</li><li>• A beneficiary or a prescriber may request a reconsideration by completing this form.</li><li>• Beneficiary and/or prescriber is encouraged to submit any additional information that could result in an override of the determination.</li></ul>	
PA REQUEST INFORMATION:	
Date of Request: _____ Requested By: <input type="checkbox"/> Prescriber <input type="checkbox"/> Beneficiary	
Drug Name: _____ Drug Strength: _____ Quantity: _____	
Date of Denial Notification: _____ Tracking # (found on denial letter) if available _____	
<b>RATIONALE/MEDICAL REASON FOR RECONSIDERATION</b>	
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____	
Beneficiary or Prescriber Signature: _____ Date: _____	

SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

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08/25/2025