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PHARMACY MEDICATION APPEALS FORM

INSTRUCTIONS:
This form is to be used by the member, an authorized representative or a practitioner/provider to request a redetermination/appeal for a previously denied medication prior authorization.

Complete this form and fax to: CDS Group Health at 775-770-9057
Or mail to: CDS Group Health/ATTN: PHARMACY APPEALS, P.O. Box 50190, Sparks, NV 89435
Or call: 775-352-6900 or 800-455-4236 (TTY users should call 711), Monday-Friday, 8 a.m. to 5 p.m. PT. For questions regarding the process, contact CDS Group Health Customer Service at 775-352-6900 or 800-455-4236.

REVIEW CRITERIA:
The following criteria are used in reviewing medication requests:

1. The use of Formulary Drug Products that will negatively impact the member's health.
2. The member has failed an appropriate trial of Formulary or related medications.
3. The choices available in the Drug Formulary are not suited for the present member care need and the drug selected is required for member safety.
4. The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to member care.

☐**REQUEST FOR EXPEDITED (URGENT) REVIEW:** *BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.*

PATIENT INFORMATION		**PHYSICIAN INFORMATION**	
*NAME:		*NAME:	
*ID#:		*SPECIALTY:	
*DATE OF BIRTH:		*NPI/DEA#:	
DIAGNOSIS (ICD-10 CODE IF KNOWN)		*PHONE#:	*FAX#:
REQUESTED DRUG INFORMATION		**PHARMACY INFORMATION**	
*REQUESTED DRUG:		NAME:	
*STRENGTH:		PHONE#:	FAX#:
*QUANTITY (PER MONTH):	*DOSAGE FORM:	LENGTH OF TREATMENT:	
*DIRECTIONS:			
REASON OF MEDICATION REQUEST (PLEASE BE SPECIFIC, GIVE DETAIL):			
OTHER MEDICATIONS TRIED AND/OOR FAILED (PLEASE BE SPECIFIC, GIVE DETAIL)			
OTHER PERTINENT HISTORY (RELATIVE OR PERTAINING TO THIS REQUEST)			