Prescription Drug Reconsideration Request Form

Fax to: 612-632-8815

Please call 612-596-9914 *immediately* when request is faxed

Hennepin Health
300 South Sixth Street, MC 604
Minneapolis, Minnesota 55487-0604

Recipient Information

RECIPIENT NAME		RECIPIENT ID NUMBER
CITY	STATE	DATE OF BIRTH (MM/DD/YYYY)

Provider Information

PROVIDER NAME		NPI
CITY	STATE	PHONE NUMBER ( )
PROVIDER SIGNATURE	DATE	FAX NUMBER ( )

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		NPI
CITY	STATE	PHONE NUMBER ( )

Request Information — Provide a copy of the original prior authorization request and denial letter.

DATE OF ORIGINAL REQUEST	ORIGINALLY REQUESTED BY ☐ Prescriber ☐ Pharmacy	DATE OF DENIAL NOTIFICATION	IS ADDITIONAL INFORMATION BEING SUBMITTED? ☐ Yes ☐ No

Requester is encouraged to submit any additional information to support the request for appeal including, for example, clinic notes and dates of previous medication trials.

Rationale/Medical Reason for Disagreement (attach additional documentation if needed)

FOR HENNEPIN HEALTH USE ONLY

DETERMINATION ☐ Approved ☐ Denied Notification	SENT TO ☐ Prescriber ☐ Pharmacy	DATE SENT

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