



Medicaid, Healthy Michigan Plan (HMP), Children's Special Health Care Services (CSHCS), Medicare/Medicaid Eligible (MME)\*

### PHARMACY – INTERNAL APPEAL REQUEST FORM

*\*Please complete ONE (1) form per drug request*

**Fax this form to 1-877-852-4070**

**PRIORITY LEVEL OF REQUEST:**

- Standard** - Decisions within 24 hours with extension up to 7 calendar days.
- Urgent** - Decisions within 24 hours with extension up to 72 hours; defined when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function.

Date of Request: \_\_\_\_\_

## PRESCRIBER

Prescriber Name: \_\_\_\_\_ Direct Phone Number: \_\_\_\_\_  
*First Last*

Prescriber NPI: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Prescriber Specialty: \_\_\_\_\_

Name and title of person completing this form: \_\_\_\_\_

## MEMBER

Member Name: \_\_\_\_\_ Medicaid ID Number: \_\_\_\_\_  
*First Last*

Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Member Address: \_\_\_\_\_

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

Height: \_\_\_\_\_  in.  cm Weight: \_\_\_\_\_  lbs.  kg

Allergies: \_\_\_\_\_

## DRUG

<i>Drug Name</i>	<i>Strength</i>	<i>Dose/Frequency</i>	<i>Formulation (tablet, capsule, gel, lotion etc.)</i>
Diagnosis (ICD-10 Code): _____			<input type="checkbox"/> New Start <input type="checkbox"/> Continuation

Previously tried and failed medications:

<i>Name of Medication</i>	<i>Reason for Failure</i>	<i>Dates</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Continued on next page ►*

Pertinent laboratory test or other objective information:

<i>Procedure</i>	<i>Findings</i>	<i>Dates</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other pertinent information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

UPHP Medicaid/HMP/CSHCS/MME Formularies and prior authorization criteria are available on our website: <https://www.uphp.com/pharmacy/medicaidformularies/>

Medical pharmacy requests (drugs administered by a provider) are submitted via the UPHP Assist Portal. Out-of-Network Providers may submit via fax using this form:

<https://www.uphp.com/wp-content/uploads/pharmacy/UPHPMedicalPharmacyPARRequestForm.pdf>

**Mail requests to:**

**Express Scripts  
Attn: Clinical Appeals Department  
PO Box 66588  
St Louis, MO 63166-6588**

**Phone: 1-866-902-6743  
(800-716-3231 TTY)**

\*For Medicare/Medicaid Eligible members, UPHP provides only Medicaid benefit coverage. This does not include members enrolled in UPHP MI Coordinated Health (HMO-DSNP).