DisclosedRx
The Fiduciary and Fully Disclosed PBM®

PO Box 701
Washington, IN 47501
Phone: 480-561-6005
Fax: 602-585-0588

Appeal Request Form

This form should only be submitted for cases where a prior authorization request was submitted, and a formal denial has been issued. Requests will not be accepted if the denial was due to lack of provider response. In such cases, a new prior authorization must be submitted before an appeal can be initiated.

☐ **Standard** ☐ **Urgent**

Patient Information

Patient Name: _____ **DOB (mm/dd/yyyy):** _____ **Gender:** _____

Address: _____ **City:** _____ **State & Zip:** _____

Cardholder ID: _____ **Group #:** _____ **Relationship Code:** _____

Phone Number: _____ **Email address:** _____

Prescriber Information

Prescriber Name: _____ **Specialty:** _____ **NPI:** _____

Address: _____ **City:** _____ **State & Zip:** _____

Office Contact: _____ **Phone Number:** _____ **Fax Number:** _____

Medication Information

Drug Name: _____ **Strength:** _____ **Quantity:** _____

Directions: _____ **Day Supply:** _____

Indicate Request Type: ☐**New Start** ☐**Renewal** **Therapy Start Date (if applicable):** _____

Diagnosis: _____ **ICD 10 Code:** _____

Appeal Request Information

*****Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays*****

1. **Is the requested agent being used for an FDA approved indication?** ☐**Yes** ☐**No**
2. **Is the requested agent dosed appropriately for an FDA approved indication?** ☐**Yes** ☐**No**
3. **Does the patient have any FDA contraindications to the requested agent?** ☐**Yes** ☐**No**
4. **For renewal requests: Has the patient had a positive clinical response to therapy? Must submit objective documentation.** ☐**Yes** ☐**No**
5. **Please list all of the medications that have been previously used to treat this diagnosis or are contraindicated for this patient. Please include medication names, strengths, dosage forms, trial dates, and outcome.**

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6. Please provide any additional supporting documentation that should be reviewed (attached or provided below):

Additional Comments:

Prescriber Signature: _____ **Date:** _____

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501