# Pharmacy Grievance and Appeal Form

**Fax this form and supporting information to 858-357-2645**

| Requester Information | | |
|---|---|---|
| **Last Name:** | **First Name:** | **Phone #:** |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |

| Patient Information | | |
|---|---|---|
| **Last Name:** | **First Name:** | |
| **ID #:** | **Date of Birth:** | |
| **Phone #:** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |

| Prescriber Information | | |
|---|---|---|
| **Last Name:** | **First Name:** | |
| **NPI#:** | **Specialty:** | |
| **Phone #:** | **Fax #:** | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |

**Describe your complaint or appeal. Please provide as much detail as possible and attach all relevant information on additional pages if needed**.

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☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that an urgent review is needed for the appeal request to avoid seriously jeopardizing the patient's health or ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the requested medication.

**I certify that the above information is accurate and complete to the best of my knowledge.**

**Signature:** _____ **Date:** _____

**For questions, contact OHSU PBM Services at 1-833-631-7991**