**Pharmacy Appeal Form**

*Complete a separate form for each prescription that is part of the appeal.*

|  |  |
| --- | --- |
| **Prescription #:**       | **Medication name:**       |
| **Dates of dispensing being appealed:**       |
|  |
| **1. The initial finding is regarding:** *Check all that apply* |
| [ ]  Invalid day supply | [ ]  Use as directed | [ ]  Compound billing error |
| [ ]  Quantity over-dispensed | [ ]  Quantity billing error | [ ]  Other |
| [ ]  Missing hardcopy or signature log | [ ]  Invalid DAW |  |
| **2. Reason for appeal:** |
| [ ]  Documentation enclosed supports manner of dispensing |
| [ ]  Initial audit finding does not match pharmacy records |
| [ ]  Other       |
| **3. Written statement:** |
| *Please explain the nature of this appeal request, including any circumstances that contributed to the manner of dispensing for this prescription. If documentation that was not provided at the time of the audit is being submitted, please explain why this documentation was not provided when originally requested. (Attach additional sheets if more space is needed.)*      |
| **4. Documentation enclosed:** *Attach supporting documentation to this form* |
| [ ]  Original hard copy | [ ]  Pharmacy computer system documentation |
| [ ]  Prescriber letter | [ ]  Other (describe): |