TRISTAR®

Arkansas Medication Reconsideration Form

Once completed, return form to Fax: 714-245-4775 or email to pharmacyteam@tristargroup.net.

Patient Information

Name (Last, First, Middle):

Date of Birth (MM/DD/YYYY):

Date of Injury (MM/DD/YYYY):

Claim Number:

Requesting Provider Information

Provider Name:
Provider Credential (MD, NP, PA, etc.):
NPI number:
Clinic/facility name:
Address:
City, State, Zip code:
Contact Name:
Phone number:
Fax number:
Email address:

Medication Request Information

MEDICATION NAME	DOSE	QUANTITY	DAYS SUPPLY	DIRECTIONS FOR USE

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Required Clinical Information

Diagnosis(es) related to this request (required) (*If all diagnoses are not associated with all drugs requested, please indicate which drug is associated with each below diagnosis)	ICD-Code (required)

Provide clinical rationale to support this request. Clinic notes, letter of medical necessity, and/or other supporting documentation may also be submitted/attached to this request.

Previous medications tried and failed (include dose, directions for use, duration)	Reason for discontinuation	Date of discontinuation

Requesting provider signature

Date