



Tennessee Bureau of Workers' Compensation  
220 French Landing Drive, I-B  
Nashville, TN 37243-1002  
615-532-8700

**REQUEST FOR EXPEDITED DETERMINATION-APPEAL OF A DENIED PRESCRIPTION**

This form is to be used to request the continued use of a drug previously prescribed and dispensed that is now in a "Needs Prior Approval" status under the Tennessee Bureau of Workers' Compensation Formulary and has been denied by the Insurance Carrier or the Utilization Review Organization

1. **Requester:** (Circle one) **Prescribing Physician** or **Pharmacy**      **Date of Request:** \_\_\_\_\_
2. \_\_\_\_\_  
**Patient Name (Please print or type)**      **State File #**      **Date of Injury**      **DOB**      **SSN**
3. \_\_\_\_\_  
**Ins. Carrier Name**      **Claim #**      **Adjuster's Name**      **Telephone, Fax# or E-mail**
4. \_\_\_\_\_  
**Prescribing Physician Name**      **DEA #**      **Phone #**      **Fax# or Email**
5. \_\_\_\_\_  
**Pharmacy Name**      **Phone #**      **Fax #**
6. \_\_\_\_\_  
**Prescription Drug Name**      **Dosage**      **Frequency**      **Duration**

7. **Please explain the potential medical emergency or the reason a substitution is not appropriate:**

\_\_\_\_\_

\_\_\_\_\_

8. I hereby certify that:

- The Prior Approval request for the previously prescribed drug identified above has been denied by the insurance carrier or it's Utilization Review Organization.
- The denial poses an unreasonable risk of a medical emergency to the patient named above by either:
  - Placing the patient's health or bodily function in serious jeopardy; or,
  - Possibly causing serious dysfunction of a body organ or part.
- No satisfactory substitution is available or that there is a valid medical reason a substitution cannot be made.
- The potential medical emergency has been documented above.
- The adjuster, prescribing doctor, patient, and dispensing pharmacy have been copied on this request.
- The denial of the request for reconsideration was received within five business days of the date listed below.

9. \_\_\_\_\_  
**Requester: Name (Printed)**      **Signature**      **Date**

**Call: 615-532-8700, then return this completed form, a copy of the latest office note, the UR denial letter and a list of all current prescriptions by fax to 615-253-5265 or by email to [ur.appeals@tn.gov](mailto:ur.appeals@tn.gov) ATTN: Medical Director.**