DRUG UTILIZATION REVIEW (DUR) PROGRAM
STATE AGENCY CONTACT FORM

STATE MEDICAID AGENCY NAME	

STATE DUR CONTACT

Person responsible for state DUR and must have a valid state email address.

NAME OF CONTACT	
EMAIL ADDRESS	
TELEPHONE NUMBER (Area Code/Ext.)	
FAX NUMBER (Area Code)	
STREET ADDRESS	
CITY	
STATE	
ZIP CODE	

STATE PHARMACY DIRECTOR

NAME OF CONTACT	
EMAIL ADDRESS	
TELEPHONE NUMBER (Area Code/Ext.)	
FAX NUMBER (Area Code)	
STREET ADDRESS	
CITY	
STATE	
ZIP CODE	

STATE MEDICAID DIRECTOR

NAME OF CONTACT	
EMAIL ADDRESS	
TELEPHONE NUMBER (Area Code/Ext.)	
FAX NUMBER (Area Code)	
STREET ADDRESS	
CITY	
STATE	
ZIP CODE	

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