

**DRUG UTILIZATION REVIEW (DUR) PROGRAM  
STATE AGENCY CONTACT FORM**

<b>STATE MEDICAID AGENCY NAME</b>	
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**STATE DUR CONTACT**

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

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

**STATE PHARMACY DIRECTOR**

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

**STATE MEDICAID DIRECTOR**

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