## 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	

CMS-R-153 (Expires: TBD) / OMB No. 0938-0659/ Rev. 6/2020

PRA Disclosure Statement This form is required by states to report contact information for individuals involved in the Medicaid Drug Rebate and Drug Utilization Review Programs. It is required only when there are changes to what is currently reported to CMS. The State's use of this form is considered mandatory under the authority of Section 1927 of the Social Security Act. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0659. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.