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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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.