OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

Physician / Outpatient Administered Medication Prior Authorization Request

Member Name: _____ ***Date of Birth:*** _____

Member ID: _____ ***Weight:*** _____

Section 1 (Drug Information)

Medication Name: _____ ***Strength:*** _____

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

HCPCS Code: _____ ***Billing Units Per Dose:*** _____ ***J.W. Units:*** _____

Section 2 (Billing Provider Information)

Provider Name: _____ ***Phone:*** _____

OHCA Provider #: _____ ***Fax:*** _____

Section 3 (To Be Completed By Prescriber)

Diagnosis: _____

Previous Tier Trials *(if applicable)*: _____

_____

Additional Comments *(including applicable lab data)*: _____

Prescriber Name *(print)* : _____

Prescriber Name *(signature)*: _____

Prescriber NPI: _____ ***Date:*** _____

Please provide the requested information and return to:

University of Oklahoma College of Pharmacy *Pharmacy Management Consultants* *Prior Authorization Department*	*Fax* *Toll Free: (800) 224-4014*	*Phone* *Toll Free (800) 522-0114* *(Select option 4.)*

CONFIDENTIALITY NOTICE

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.