Sooner Care

University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4

State of Oklahoma Oklahoma Health Care Authority Diabetic Supplies Prior Authorization Form

Member Name:	
Member ID:	Date of Birth: / / /
Section I (To Be Completed by Dispensing Pharmacy)	
Pharmacy Name:	Pharmacy Phone: ()
Pharmacy NPI:	Pharmacy Fax:
NDC:	Requested Fill Date:
Product:	Quantity: Day Supply:
Prescriber Name:	Prescriber (Phone:
Prescriber NPI:	Prescriber ()
Section II (To Be Completed by Prescriber)	
Number of Tests/Day: If greater than established quantity limit, please provide a detailed description of reason member needs more frequent testing:	
Diagnosis (Please check one):	ICD:
☐ Insulin-Using Diabetes (No Insulin Pump)	
☐ Insulin-Using Diabetes (Insulin Pump)	
☐ Non-Insulin Using Diabetes	
☐ Gestational Diabetes. Please provide estimated date of delivery:	
□ Other	
Has the prescriber verified that the member has been compliant for at least 30 days with testing frequency ordered based on the member's blood glucose log?	
Most recent date of office visit verifying member exhibits medical necessity for requested testing frequency?	
Prescriber Signature:	Date:

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