

State of Oklahoma **Oklahoma Health Care Authority**

Petition for Medication Prior Authorization

Member Name:					_
Member ID:			Date of Birth:		
Section I (To Be Completed By Dispensing Pharmacy)					
Pharmacy Name:			Pharmacy Phone:	()	-
Pharmacy NPI:			Pharmacy Fax:	()	-
Medication:		Strength:	Regin	nen:	_
NDC Number:	-	-			
Fill Date:	Fill Qu	antity:	_ Day Supply:	Refills:	_
Pharmacist Name	e (signed):		Dat	te:	_
Prescriber Name	(printed):		Prescriber Phone:	()	-
Prescriber NPI:			Prescriber Fax:	()	-
Section 2 (To Be Completed By Appropriate Health Care Provider)					
Diagnosis / Dise	ase State:			<i>`=</i> 78	3SSS
Previous Tier-I T	rials / OTC Trials:				_
	le medication name, ange of trial, and ilure of trial.)				-
Prescriber Signature:(Required for Schedule II Drugs)				Date:	

Please provide the requested information and return to:

For SoonerCare Pharmacy Information, see: www.okhca.org

University of Oklahoma College of Pharmacy **Pharmacy Management Consultants** Prior Authorization Department

Fax OKC Metro: (405) 271-4014 Toll Free: (800) 224-4014

<u>Phone</u> OKC Metro: (405) 522-6205* Toll Free (800) 522-0114*

*(Select option 4.)

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