

Erythropoietin Stimulating Agents

Prior Authorization Request

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

ID: _____

Section 1 (Drug Information)

Medication Name: _____ **Strength:** _____

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

(Complete This Section If Dispensing Provider Is A Physician's Office or Outpatient Facility)

HCPCS Code: _____ **Billing Units:** _____

(Complete This Section If Dispensing Provider Is A Pharmacy)

NDC Number: _____

Fill Quantity: _____ **Day Supply:** _____ **Refills:** _____

Section 2 (Dispensing Provider Information)

Provider Name: _____ **Phone:** _____

Provider NPI: _____ **Fax:** _____

Section 3 (To Be Completed By Appropriate Health Care Provider)

Diagnosis: _____

Hb: _____ **g/d L** —or— **Hct:** _____ **%** **Date Recorded:** _____

Additional Comments: _____

Documented By: _____ **Date:** _____

Prescriber Name: _____ **Phone:** _____

Prescriber NPI: _____ **Fax:** _____

Please provide the requested information and return to:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Prior Authorization Department
PO Box 26901; ORI W-4403
Oklahoma City, OK 73190

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

Phone
OKC Metro: (405) 522-6205
Toll Free (866) 522-0114
(Select option 4.)

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

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