SoonerCare
Oklahoma Health Care Authority

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

OHCA Revised 04/24/2014 PHARM-17