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

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