PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
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

SoonerCare
Oklahoma Health Care Authority

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 Fax:** ( ) -

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? ☐ **Yes** ☐ **No**

Most recent date of office visit verifying member exhibits medical necessity for requested testing frequency? _____

Prescriber Signature: _____ **Date:** _____

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