SoonerCare
Oklahoma Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Clotting Factor Replacement Dispensing

Pharmacy NPI:_____ ***Pharmacy Phone:*** _____ ***Pharmacy Fax:***_____

Pharmacy Name:_____ ***Pharmacist Name:***_____

Dispensing Information

Patient Name*	SoonerCare ID	Date Dispensed	Prescriber Name	Product	Prescribed Dose	Units per Vial	Number of Vials	Units per Dose₮	Type of Treatment¥	Proof of Delivery+ (Y or N)

*Can be used for more than one patient

₮f more than 1 vial per dose please indicate vials to be given to make one dose (example: 1092 unit vial + 576 unit vial = 1668 units per dose)

¥P=Prophylaxis, E=Episodic, B=Breakthrough, if breakthrough please specify date of last breakthrough bleed

+Proof of delivery should consist of member or caregiver's signature stating the product was received and should be dated

Pharmacist Signature: _____ **Date:** _____

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

OHCA Approved 7/6/2016