



**Physician / Outpatient Administered Medication  
Prior Authorization Request**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Member ID:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Section 1 (Drug Information)**

**Medication Name:** \_\_\_\_\_ **Strength:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

**HCPCS Code:** \_\_\_\_\_ **Billing Units Per Dose:** \_\_\_\_\_ **J.W. Units:** \_\_\_\_\_

**Section 2 (Billing Provider Information)**

**Provider Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**OHCA Provider #:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Section 3 (To Be Completed By Prescriber)**

**Diagnosis:** \_\_\_\_\_

**Previous Tier Trials (if applicable):** \_\_\_\_\_

**Additional Comments (including applicable lab data):** \_\_\_\_\_

**Prescriber Name (print):** \_\_\_\_\_

**Prescriber Name (signature):** \_\_\_\_\_

**Prescriber NPI:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please provide the requested information and return to:**

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Prior Authorization Department

*Fax*  
Toll Free: (800) 224-4014

*Phone*  
Toll Free (800) 522-0114  
(Select option 4.)

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