OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Pharmacy Prior Authorization Amendment Form

Member Name: _____ ***Date of Birth:*** _____ ***Member ID #:*** _____

Pharmacy (or Billing Provider) NPI: _____ ***Pharmacy Name:*** _____

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

AMENDMENTS CAN ONLY BE REQUESTED ON APPROVED PRIOR AUTHORIZATIONS

Prescription Requiring Prior Authorization Change:

Medication Name: _____ **Medication NDC:** _____

Fill Date Requested: _____ **Quantity:** _____ **Days Supply:** _____

Prescriber Name: _____ **Prescriber NPI:** _____

Prescriber Fax: _____

Reason For Amendment:

☐ **Change of Pharmacy**

☐ **Change of NDC**

☐ **Other:** _____

_____

For changes in medication, strength, or regimen, a new Universal Petition for Medication Authorization form (Pharm-04) will need to be submitted unless the medication has a medication specific prior authorization form. All changes to medical prior authorizations will need to be submitted on a new Outpatient Medication Petition form (Pharm-18) unless the medication has a medication specific prior authorization form.

Additional Information: _____

_____

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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 or (405) 271-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE