

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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<p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</p> <p>University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p>Fax: 1-800-224-4014 or (405) 271-4014 Phone: 1-800-522-0114 Option 4</p>	<p>CONFIDENTIALITY NOTICE</p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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