

State of Oklahoma Oklahoma Health Care Authority

**Petition for Medication Prior Authorization** 

Member Name:							
Member ID:		Date of Birth:					
Section I (To Be Completed By Dispensing Pharmacy)							
Pharmacy Name:		Pharmacy Phone:					
Pharmacy NPI:		Pharmacy Fax:	()				
Medication:	Strength:	Regin	nen:				
NDC Number:							
Fill Date:	Fill Quantity:	Day Supply:	Refills:				
Pharmacist Name (signed): Date:							
Prescriber Name (print	ed):	Prescriber Phone:					
Prescriber NPI:		Prescriber Fax:					

## Section 2 (To Be Completed By Appropriate Health Care Provider)

Diagnosis / Disease State:ICD-9:						
Previous Tier-1 Trials / OTC Tri (Important: Include medication name dosage, date range of trial, and reason for failure of trial.)						
Prescriber Signature:	(Required for Schedule II	(Required for Schedule II Drugs)				
Please provide the requested	information and return to:		CONFIDENTIALITY			
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Prior Authorization Department	<u>Fax</u> OKC Metro: (405) 271-4014 Toll Free: (800) 224-4014	<u>Phone</u> OKC Metro: (405) 522-6205* Toll Free (800) 522-0114* *(Select option 4.)	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, distribu-tion, or use of the contents of this information is prohibited. If you have received this document in error,			
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to verify their destruction.