

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, | | | |
| For SoonerCare Pharmacy Information | please notify the sender immediately by telephone to arrange for the return of the trans-mitted documents or | | | | | |

to verify their destruction.