



**Statement of Medical Necessity for Ingredient Duplication Override**

Pharmacy Management Consultants - Prior Authorization  
Unit Phone: 405-522-6205 or 1-800-522-0114 option 4  
Fax: 405-271-4014 or 1-800-224-4014

After completing this form, please **fax** this form and any requested documentation to Pharmacy Management Consultants. Please make sure that the member's Medicaid ID Number is on every page faxed.

**THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:**

Member's Name:	Member's ID Number:
Member's Date of Birth:	Dispensing Pharmacy Phone Number: (            )            -
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number: (            )            -
Dispensing Pharmacy NPI:	Requested Drug NDC Number:
Prescriber Name:	Prescriber NPI:
Prescriber Phone Number:	Prescriber Fax Number:

<b><u>Previous Fill</u></b> Hydrocodone strength: Regimen: Fill Date: Day Supply: Quantity: Prescriber Name:	<b><u>Requested Fill</u></b> Hydrocodone strength: Regimen: Fill Date: Day Supply: Quantity:
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**THIS SECTION MUST BE COMPLETED AND SIGNED BY THE**

**PRESCRIBER: Ingredient Duplication Override**

- Specific diagnosis: \_\_\_\_\_
- Detailed description of reason patient needs a different strength of the same medication/ or change to different physician:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SoonerCare may request additional supporting documentation.**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)**