

# Erythropoietin Stimulating Agents

## Prior Authorization Request

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member**

**ID:** \_\_\_\_\_

### Section 1 (Drug Information)

**Medication Name:** \_\_\_\_\_ **Strength:** \_\_\_\_\_

**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

(Complete This Section If Dispensing Provider Is A Physician's Office or Outpatient Facility)

**HCPCS Code:** \_\_\_\_\_ **Billing Units:** \_\_\_\_\_

(Complete This Section If Dispensing Provider Is A Pharmacy)

**NDC Number:** \_\_\_\_\_

**Fill Quantity:** \_\_\_\_\_ **Day Supply:** \_\_\_\_\_ **Refills:** \_\_\_\_\_

### Section 2 (Dispensing Provider Information)

**Provider Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Provider NPI:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

### Section 3 (To Be Completed By Appropriate Health Care Provider)

**Diagnosis:** \_\_\_\_\_

**Hb:** \_\_\_\_\_ **g/d L** —or— **Hct:** \_\_\_\_\_ **%** **Date Recorded:** \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_

**Documented By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prescriber Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Prescriber NPI:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

#### Please provide the requested information and return to:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Prior Authorization Department  
PO Box 26901; ORI W-4403  
Oklahoma City, OK 73190

Fax  
OKC Metro: (405) 271-4014  
Toll Free: (800) 224-4014

Phone  
OKC Metro: (405) 522-6205  
Toll Free (866) 522-0114  
(Select option 4.)

For SoonerCare Pharmacy Information, see: [www.okhca.org](http://www.okhca.org)

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