

**State of Oklahoma  
Oklahoma Health Care Authority  
Clotting Factor Replacement Dispensing**

**Pharmacy NPI:** \_\_\_\_\_  
**Pharmacy Name:** \_\_\_\_\_

**Pharmacy Phone:** \_\_\_\_\_  
**Pharmacist Name:** \_\_\_\_\_

**Pharmacy Fax:** \_\_\_\_\_

**Dispensing Information**

Patient Name*	SoonerCare ID	Date Dispensed	Prescriber Name	Product	Prescribed Dose	Units per Vial	Number of Vials	Units per Dose <sup>†</sup>	Type of Treatment <sup>‡</sup>	Proof of Delivery <sup>††</sup> (Y or N)

\*Can be used for more than one patient

<sup>†</sup>If more than 1 vial per dose please indicate vials to be given to make one dose (example: 1092 unit vial + 576 unit vial = 1668 units per dose)

<sup>‡</sup>P=Prophylaxis, E=Episodic, B=Breakthrough, if breakthrough please specify date of last breakthrough bleed

<sup>††</sup>Proof of delivery should consist of member or caregiver's signature stating the product was received and should be dated

**Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:  
University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit  
Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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