SoonerCare
Oklahoma Health Care Authority

Physician / Outpatient Administered Medication Prior Authorization Request

Member Name: _____ ***Date of Birth:*** _____

Member ID: _____ ***Weight:*** _____

Section 1 (Drug Information)

Medication Name: _____ ***Strength:*** _____

Dose: _____ ***Regimen:*** _____ ***Start Date:*** _____

HCPCS Code: _____ ***Billing Units Per Dose :*** _____

Section 2 (Billing Provider Information)

Provider Name: _____ ***Phone:*** _____

OHCA Provider #: _____ ***Fax:*** _____

Section 3 (To Be Completed By Prescriber)

Diagnosis: _____

Previous Tier Trials *(if applicable)*: _____

_____

Additional Comments *(including applicable lab data)*: _____

Prescriber Name *(print)* : _____

Prescriber Name *(signature)*: _____

Prescriber NPI: _____ ***Date:*** _____

Please provide the requested information and return to:

University of Oklahoma College of Pharmacy *Pharmacy Management Consultants* *Prior Authorization Department*	*Fax* *OKC Metro: (405) 271-4014* *Toll Free: (800) 224-4014*	*Phone* *OKC Metro: (405) 522-6205* *Toll Free (866) 522-0114*

For SoonerCare Pharmacy Information, see: www.okhca.org/providers/rx

OHCA Revised 04/24/2014 PHARM–18