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*** _____ ***ICD-10:*** _____

***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*<br>*Pharmacy Management Consultants*<br>*Prior Authorization Department* | *Fax*<br>*OKC Metro: (405) 271-4014*<br>*Toll Free: (800) 224-4014* | *Phone*<br>*OKC Metro: (405) 522-6205*<br>*Toll Free (800) 522-0114*<br>*Option 4* |

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

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