

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
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 (800) 522-0114
Option 4

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

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