

State of Oklahoma
Oklahoma Health Care Authority
Erythropoietin Stimulating Agents Prior Authorization Request

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Medication Name: _____ Strength: _____

Dose: _____ Regimen: _____ Start Date: _____

Physician billing: HCPCS code: _____ Billing units: _____

Pharmacy billing: NDC: _____ Fill Quantity: _____ Day Supply: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____

Criteria

Diagnosis: _____ ICD: _____

Hb: _____ g/dL or Hct: _____ % Date Recorded: _____

Is the member on dialysis? Yes ___ No ___

Additional Information: _____

Prescriber Signature: _____ Date: _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

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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