SoonerCare
Oklahoma Health Care Authority

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

PETITION FOR TUBERCULOSIS (TB) RELATED THERAPY AUTHORIZATION

ONLY ONE INDIVIDUAL PER PETITION

Member Name: ______________________________ *Birthdate:* __ __ / __ __ / __ __ __ __

Member ID: __ __ __ __ __ __ __ __ __

TO BE COMPLETED BY DISPENSING PHARMACY

Dispensing Pharmacy Name: ______________________________

Dispensing Pharmacy NPI: __ __ __ __ __ __ __ __ __ __

Dispensing Pharmacy Phone Number: (__ __ __) __ __ __ - __ __ __ __

Dispensing Pharmacy Fax Number: (__ __ __ __ __ __ - __ __ __ __

NDC Number: __ __ __ __ __ - __ __ __ __ - __ __

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

Medication Name: ______________________________

Dosage: ______________________________ *Qty Prescribed:* ______________________________

Has the patient been approved for TB benefits? *Yes* ____________ *No* ____________

Please list supporting information that associates this therapy with the patient's primary diagnosis of TB (use additional sheets if necessary):

____

____

____

____

Intent of the Program is to work with Health Care Providers. Therefore, if there are circumstances relating to the treatment of the individual that would warrant additional consideration, please provide appropriate comments on the additional page.

Signature of Prescribing Physician: ______________________________

Name of Prescribing Physician (Please Print): ______________________________

Prescribing Physician's Fax Number: (__ __ __) __ __ __ - __ __ __ __

Prescribing Physician's NPI: __ __ __ __ __ __ __ __ __ __

Please Provide the Information Requested and Return to: UNIVERSITY OF OKLAHOMA
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS PRODUCT BASED PRIOR
AUTHORIZATION UNIT

Phone (405) 522-6205 Opt 4 Toll Free
800-522-0114 Opt 4
http://www.okhca.org

FAX (405) 271-4014
Toll Free 800-224-4014

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