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<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 (866) 522-0114 |
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*For SoonerCare Pharmacy Information, see: www.okhca.org/providers/rx*



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