

Petition for Medication Prior Authorization

Member Name: _____

Member ID: [][][][][][][][][][] Date of Birth: [][] / [][] / [][][][]

Section I (To Be Completed By Dispensing Pharmacy)

Pharmacy Name: _____ Pharmacy Phone: ([][]) [][] - [][][][]
Pharmacy NPI: [][][][][][][][][][] Pharmacy Fax: ([][]) [][] - [][][][]
Medication: _____ Strength: _____ Regimen: _____
NDC Number: [][][][][][] - [][][][][][] - [][][]
Fill Date: _____ Fill Quantity: _____ Day Supply: _____ Refills: _____
Pharmacist Name (signed): _____ Date: _____
Prescriber Name (printed): _____ Prescriber Phone: ([][]) [][] - [][][][]
Prescriber NPI: [][][][][][][][][][] Prescriber Fax: ([][]) [][] - [][][][]

Section 2 (To Be Completed By Appropriate Health Care Provider)

Diagnosis / Disease State: _____ ICD-9: [][][] - [][][]
Previous Tier-I Trials / OTC Trials: _____
(Important: Include medication name, dosage, date range of trial, and reason for failure of trial.)
Prescriber Signature: _____ Date: _____
(Required for Schedule II Drugs)

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*
*(Select option 4.)
For SoonerCare Pharmacy Information, see: www.okhca.org

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