

**State of Oklahoma
SoonerCare
Pharmacy Prior Authorization Amendment Form**

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

Pharmacy (or Billing Provider) NPI: _____ **Pharmacy Name:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

AMENDMENTS CAN ONLY BE REQUESTED ON APPROVED PRIOR AUTHORIZATIONS

Currently Approved Prior Authorization:

Medication name: _____ **Prescriber NPI:** _____

Prescriber Name: _____ **Prescriber Fax:** _____

Amended Information:

Medication NDC or HCPCS code: _____ **Fill Date:** _____

Regimen: _____ **Quantity:** _____ **Day supply:** _____

Reason For Amendment:

Change of Pharmacy

Change of NDC/HCPCS Code:

New NDC: _____ **New HCPCS Code:** _____

Change of Regimen (e.g., daily, twice daily):

Previous Regimen: _____ **New Regimen:** _____

Is there a change of units? Yes ___ **No** ___

Billing Units per Dose: _____ **J.W. Units:** _____

Change of Strength:

Previous Strength: _____ **New Strength:** _____

Change of End Date:

Previous End Date: _____ **New End Date:** _____

Reason for Extension: _____

Other: _____

Additional Information: _____

<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p align="center">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p align="center">Fax: 1-800-224-4014 or (405) 271-4014 Phone: 1-800-522-0114 Option 4</p>	<p align="center"><u>CONFIDENTIALITY NOTICE</u></p> <p align="center"><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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