OKLAHOMA
Health Care Authority

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: _____

_____

_____

_____

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 or (405) 271-4014
Phone: 1-800-522-0114 Option 4

CONFIDENTIALITY NOTICE