



State of Oklahoma
SoonerCare

Medication Therapy Management Services - Member Referral Form

Member Information

Member Name: _____ Member ID#: _____

Member Date of Birth: _____ Member Phone #: _____

Referring Provider/Pharmacy Information

Referring Provider Name: _____ NPI (if available): _____

Provider Phone: _____ Provider E-mail: _____

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Clinical Information

Please complete the following information:

1. Is the member enrolled in an Oklahoma Medicaid Waiver program? Yes ___ No ___
2. Does the member have Medicare? Yes ___ No ___
3. Is member consistently having difficulties with the monthly prescription limit? Yes ___ No ___
4. Is member consistently having difficulties with greater than 2 brand name medications monthly?
Yes ___ No ___
5. Please list chronic medical conditions: _____

Additional Information: _____

Please fax this form to the Medication Therapy Management program at **405-271-1563**

For questions, please contact the Medication Therapy Management program:

Phone: (866) 837-6450

E-mail: soonerarerx@ouhsc.edu

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Medication Therapy Management Services

Fax: 405-271-1563
Phone: 866-837-6450

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