SoonerCare
Oklahoma Health Care Authority

State of Oklahoma

Oklahoma Health Care Authority

Petition for Medication Prior Authorization

Member Name: ______________________________

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

Section 1 (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: ______________________________ ⁼78.˙____SSS

Previous Tier-1 Trials / OTC Trials: ______________________________

(Important: Include medication name, dosage, date range of trial, and reason for failure of trial.)

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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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