61725

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

UNIVERSAL PETITION FOR MEDICATION AUTHORIZATION

Patient Name: _____ *Birthdate:* __ / __ / ____

UCI: _____

Dosage Change ☐ *DC Previous Petition* ☐

New Prescription ☐ *Pharmacy Change* ☐

TO BE COMPLETED BY DISPENSING PHARMACY

Dispensing Pharmacy Name: _____

Dispensing Pharmacy OHCA Provider Number: _____

Dispensing Pharmacy Phone Number: (___) ___ - ____

Dispensing Pharmacy Fax Number: (___) ___ - ____

NDC Number: _____ - _____ - __ *Fill Date:* _____

Monthly Quantity: _____

Medication: _____ *Strength:* _____ *Regimen:* _____

Provider Prescriber Number _____ *Prescribing Phone Number* (___) ___ - ____

Prescribing Name (Printed): _____

Pharmacist Name (Signed): _____ *Date:* _____

TO BE COMPLETED BY APPROPRIATE HEALTH CARE PROVIDER

Diagnosis, Disease State (ICD-9/Description): ___ - __ _____

_____

Previous Tier-1 trials and/or OTC's Trial-list name, dosage, dates and reason for failure: _____

_____

Schedule II Drugs Require Physician Signature

Prescribing Name (Signed): _____ *Date:* _____

Please Provide the Information Requested and Return to:

UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS
PRODUCT BASED PRIOR AUTHORIZATION UNIT

Phone (405) 522-6205 Opt 4
Toll Free 1-800-522-0114 Opt 4

FAX (405) 271-4014
Toll Free 1-800-224-4014

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