



## **OHCA Pharmacy Provider packet:**

**Included in this packet are items that will be helpful in the process of billing Medicaid Pharmacy claims.**

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**Listed below are the items in the packet.**

**Following this are the items with a page prefacing each item as to its use.**

- 1 Call instructions on using the Customer Service line for Providers.
- 2 Epocrates.com – website subscription info to access Medicaid Formulary.
- 3 Current Tier listing of Tiered medications w/ Prior Auth. guidelines.
- 4 Universal Authorization petition
- 5 Medication Therapy Mgmt. Servs. Prior Auth. form
- 6 Quantity Limit/High Dose override form
- 7 Early Fill override form
- 8 Brand-Name Drug override form
- 9 Synagis petition
- 10 Growth Hormone petition
- 11 Tuberculosis petition
- 12 Xolair petition
- 13 Manual Pharmacy Claim form w/instructions
- 14 Manual Compound Claim form w/instructions
- 15 Medication fill process
- 16 Compound billing tips

# 1

## **Call instructions using the Customer Service line for Providers.(1 page)**

Call this number to reach the Pharmacy Helpdesk as well as other depts. in regard to billing, reimbursement, contract, medication coverage & many other questions. Several options will be listed after following the instructions and entering the provider# of your pharmacy.

# Oklahoma Medicaid Pharmacy Update

Pharmacy Help Desk Telephone Numbers 405-522-6205 option 4 or 800-522-0114 option 4  
Service Hours: Monday – Friday (8:30a – 7:00p); Saturday (9:00a – 5:00p); Sunday (11:00a – 5:00p)

Email: [medicaidrx@okhca.org](mailto:medicaidrx@okhca.org) OHCA Website: [www.okhca.org](http://www.okhca.org)

January 13, 2006

## Pharmacy Help Desk Phone Numbers Changing

The local and toll free numbers 405-271-6349 and 800-831-8921 are no longer available.  
The new numbers are:

405-522-6205 option 4

800-522-0114 option 4

The new numbers will prompt the following questions:

- 1) The first question will ask if you wish to use the voice response system or touchtone system. Stay on the line for the voice response system. If you wish to utilize the touchtone system press the pound (#) key.
- 2) The second question will ask if you are a provider or a client, say “provider” or press the number one (1) key for provider.
- 3) Next, you will be prompted to enter your provider number and location code, here you can speak or enter your nine digit provider number and alpha character for the location code and press the pound (#) key. To enter the alpha character see chart below.

A	*21	G	*41	M	*61	S	*74	Y	*93
B	*22	H	*42	N	*62	T	*81	Z	*94
C	*23	I	*43	O	*63	U	*82		
D	*31	J	*51	P	*71	V	*83		
E	*32	K	*52	Q	*72	W	*91		
F	*33	L	*53	R	*73	X	*92		

- 4) Finally, you will be prompted to select a menu option, you can say “Pharmacy Help Desk” or press the number four (4) key to reach the Pharmacy Help Desk.

These new changes will allow the Pharmacy Help Desk to view your provider information as soon as your call is received.

**Thank you for your continued service to Oklahoma’s Medicaid clients.**

**Epocrates.com – website subscription information – (2 pages)**

This is a website from which you can get a **free** subscription containing access to the full & up-to-date formulary for Oklahoma Medicaid/Soonercare drug coverage.

The website also offers access to many other formularies such as the Medicare Prescription Drug Plans.

## Epocrates Online Web Application

### FREE Version Now Available

1. Go to [www.epocrates.com](http://www.epocrates.com)
  2. Click on "Epocrates Online" (upper right hand corner)
  3. Click Register Now
    - Follow the registration steps to obtain a username and password
  4. Log into Epocrates online
    - The first thing you will need to do is set up your formularies, by clicking on the "formularies tab"
    - Highlight the formularies that you are interested in and click "Add to List"
    - Add "Oklahoma ~~Medicaid~~ <sup>SoonerCare</sup> Drug List"
- 

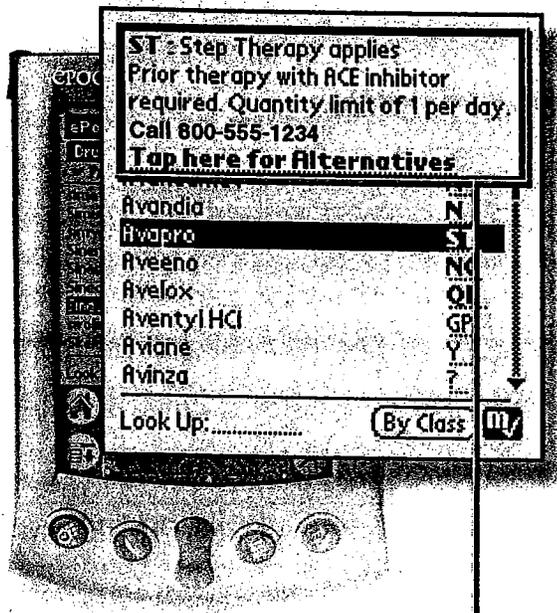
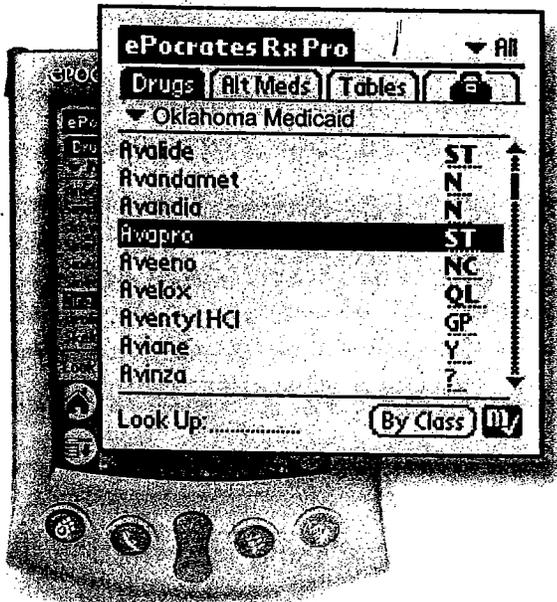
Tabs	Description
Drugs	List of drugs from the selected formulary. Dosing information, Prior Authorization info, etc.
Alt Meds	Alphabetical listing of various herbal medications
Tables**	Clinical information used by medical personnel, such as treatment protocols, (all the ACLS tables, etc.) and diagnostic tips
MultiCheck	Drug / Drug Interactions
Pill Identifier**	Mixed up meds? – search for drugs using color, clarity, shape, coating, score, and imprint code.
Med Calc**	The premium version of the Epocrates Online web-based reference gives you access to hundreds of medical calculators, clinical criteria, and decision trees, searchable by specialty.
Formularies	Select the formularies that you want to have available on the "Drugs Tab"
Abbreviations and Codes	List of abbreviations and codes commonly used in the medical field. (dosing codes, etc.)

\*\* Available in Premium versions of Epocrates Online.

# Oklahoma Health Care Authority and Epocrates® References Leading the way to reduce physician hassles and improve quality of care

Epocrates Rx® reviewed in JAMA<sup>1</sup>

“Indispensable,” “state of the art”  
and “the one to have and keep.”



Customized pop-up windows deliver drug-specific information, such as benefit design or treatment guidelines.

## Epocrates references enable point-of-care access to drug list information

- Verify status and copayment tiers
- View alternatives and generic substitutions
- Look up prior authorization requirements
- Check quantity limits
- Receive drug specific messages directly from Oklahoma Health Care Authority

## Epocrates features benefit physicians and members

- Reduce medication errors
- Minimize time dealing with pharmacy call backs
- Improve patient satisfaction
- Monitor drug list updates and changes easily

## Over 340,000 healthcare professionals use the Epocrates drug reference guide

- Determine adult and pediatric dosing
- Check for drug interactions
- Guard against adverse reactions and contraindications
- Check pricing information

## Access this powerful database easily from your handheld or desktop

- Meet the technical requirements
  - Palm OS or Pocket PC handheld with 3.0 MB of free memory, and/or
  - Personal computer with Internet access
- Download Epocrates handheld software or access Epocrates Rx Online™ from [www.epocrates.com](http://www.epocrates.com)
- Select the Oklahoma Medicaid drug list
- AutoUpdate to download the drug list to your handheld
- AutoUpdate frequently to receive updates

[www.epocrates.com](http://www.epocrates.com)



OKLAHOMA  
HEALTH CARE AUTHORITY

**Current Tier list for Oklahoma Medicaid/Soonercare pharmacy coverage. (7pages)**

This is the most current listing of information on the medications covered through a Tiered medication setup with brief Prior Authorization guidelines listed for each category of medication.

## Oklahoma Medicaid Prior Authorization Medication Tiers

NSAIDS (Non-Steroidal Anti-Inflammatory Drugs)	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p style="text-align: center;"><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li><u>Two</u> consecutive trials with Tier-1 products with inadequate results within the last 120 days*, or</li> <li>Documented FDA-approved indication for which Tier-1 medications are not indicated</li> </ul>	
<p><i>* Note: In order for previously utilized Tier-1 medications to count as trials toward a Tier-2 authorization, the client's NSAID therapy must have been continuous. Dates and dosing information for Tier-1 trials must be included on petition for authorization. Trials with OTC formulations of Tier-1 products must be dosed at full prescription strength.</i></p>	
Tier-1 (no PA required)	Tier-2 (requires PA)
diclofenac ER (Voltaren XR)	celecoxib (Celebrex)
diclofenac potassium (Cataflam)	diclofenac sodium / misoprostol (Arthrotec)
diclofenac sodium (Voltaren)	indomethacin (Indocin)
etodolac (Lodine)	naproxen sodium (Naprelan)
etodolac ER (Lodine XL)	naproxen / lansoprazole (Prevacid NapraPAC)
fenoprofen (Nalfon)	meloxicam (Mobic)
flurbiprofen (Ansaid)	piroxicam (Feldene)
ibuprofen (Motrin)	
ketoprofen (Orudis)	
ketoprofen ER (Oruvail)	
meclofenamate (Meclomen)	
mefanamic acid (Ponstel)	
nabumetone (Relafen)	
naproxen (Naprosyn)	
naproxen sodium (Anaprox)	
naproxen EC (Naprosyn EC)	
oxaprozin (Daypro)	
sulindac (Clinoril)	
tolmetin (Tolectin)	

### Antihistamines

#### Clients Under Age 21

- Loratadine OTC is covered and does not require prior authorization.
- Prior authorization of prescription antihistamines requires a documented 14-day trial of loratadine OTC within the last 30 days.

#### Clients Age 21 and above

- Prior authorization of Loratadine OTC requires a documented 14-day trial of another OTC antihistamine within the last 30 days.
- Prior authorization of prescription antihistamines requires a documented 14-day trial of loratadine OTC (covered with PA) within the last 30 days and a documented 14-day trial of another OTC antihistamine.

## Oklahoma Medicaid Prior Authorization Medication Tiers

<b>Bladder Control Medications</b>	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p style="text-align: center;"><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results, or</li> <li>Documented adverse effect or contraindication to the Tier-1 products, or</li> <li>Documented unique indication for which Tier-1 products are not indicated, or</li> <li>Documented Prior stabilization on a Tier-2 product</li> </ul>	
<ul style="list-style-type: none"> <li>Hyoscyamine can be used as adjuvant therapy, but does not count as a tier-1 trial.</li> </ul>	
Tier-1 (no PA required)	Tier-2 (requires PA)
flavoxate (Urispas)	darifenacin (Enablex)
hyoscyamine (Levbid, Levsin, Cystospaz)	oxybutynin (Oxytrol)
oxybutynin (Ditropan)	oxybutynin extended release (Ditropan XL)
solifenacin (VESicare)	tolterodine extended release (Detrol LA)
tolterodine (Detrol)	trospium (Sanctura)

<b>Anti-Ulcer Medications</b>	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p style="text-align: center;"><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results or adverse effect, or</li> <li>Documented contraindication to the Tier-1 medications, or</li> <li>Documented FDA-approved indication for which Tier-1 products are not indicated</li> </ul>	
Tier-1 (no PA required)	Tier-2 (requires PA)
OTC omeprazole (Prilosec OTC) <i>*up to BID dosing</i>	esomeprazole magnesium (Nexium)
generic Rx omeprazole <i>*up to BID dosing</i>	prantoprazole sodium (Protonix)
lansoprazole (Prevacid) – capsules <i>*BID dosing requires PA</i>	
rabeprazole sodium (Aciphex) <i>*BID dosing requires PA</i>	
omeprazole (Zegerid) <i>*BID dosing requires PA</i>	
<p><u>The following medications also require authorization :</u></p> <ul style="list-style-type: none"> <li>brand Rx omeprazole (Prilosec)</li> <li>lansoprazole (Prevacid) – solutabs &amp; granules</li> <li>ranitidine (Zantac) – all forms except tablets &amp; syrup</li> <li>esomeprazole IV (Nexium IV)</li> </ul>	

# Oklahoma Medicaid Prior Authorization Medication Tiers

Stimulant / ADHD Medications		
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary for clients under age 21.</li> </ul>		
<ul style="list-style-type: none"> <li>Prior authorization is required for all stimulants / ADHD medications for clients age 21 and older.</li> </ul>		
<p><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results, or</li> <li>Documented adverse effect or contraindication to the Tier-1 products, or</li> <li>Documented FDA-approved indication for which Tier-1 products are not indicated</li> </ul>		
<p><u>Tier-3 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of <u>two</u> Tier-1 medications with inadequate results</li> </ul>		
<ul style="list-style-type: none"> <li>Dosing in excess of 1.5 times the FDA approved maximum is not covered.</li> <li>Concurrent use of multiple products from this category is not covered. (For example, Strattera + Stimulant or Methylphenidate + Amphetamine)</li> </ul>		
Tier-1 (no PA required if under age 21)	Tier-2 (requires PA)	Tier 3 (requires PA)
amphetamine salt combo (Adderall)	atomoxetine (Strattera)	methamphetamine (Desoxyn)
amphetamine salt combo (Adderall XR)	methylphenidate ER (Metadate CD, Ritalin LA)	pemoline (Cylert)
dextroamphetamine (Dexedrine, Dextrostat)	methylphenidate ER (Concerta)	
dexmethylphenidate (Focalin, Focalin XR)	methylphenidate patch (Daytrana)	
methylphenidate (Ritalin)		
methylphenidate SR (Ritalin SR)		
methylphenidate ER (Metadate ER)		

STATINS	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results after a minimum of 6-8 weeks of continuous therapy at standard to high dose, or</li> <li>Documented adverse effect or contraindication to the Tier-1 medications, or</li> <li>Documented increased risk for drug interactions--Specifically: concurrent immunosuppressant therapy, HIV antiretroviral therapy, and therapy with other potent inhibitors of CYP450 system.</li> </ul>	
Tier-1 (no PA required)	Tier-2 (requires PA)
atorvastatin (Lipitor)	ezetimibe / simvastatin (Vytorin)
fluvastatin (Lescol, Lescol XL)	lovastatin (Altoprev & Mevacor)
lovastatin (generic)	lovastatin / niacin (Advicor)
pravastatin (Pravachol)	pravastatin (Pravigard)
simvastatin (Zocor)	rosuvastatin (Crestor)

# Oklahoma Medicaid Prior Authorization Medication Tiers

Antidepressants	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p style="text-align: center;"><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication within the last 6 months with inadequate results after a minimum of 4 weeks of continuous therapy, or</li> <li>Documented adverse effect, drug interaction, or contraindication to the Tier-1 medications, or</li> <li>Documented FDA-approved indication for which Tier-1 medications are not indicated, or</li> <li>Documented prior stabilization on the Tier-2 medication within the last 100 days</li> </ul>	
<ul style="list-style-type: none"> <li>Petitions for a Tier-2 medication may be submitted for consideration when a unique client-specific situation exists, or when prescribed by a psychiatrist.</li> </ul>	
SSRIs (Selective Serotonin Reuptake Inhibitors)	
Tier-1 (no PA required)	Tier-2 (requires PA)
citalopram (generic tabs only)	citalopram (Celexa tabs and liquid)
fluoxetine (Prozac)	escitalopram (Lexapro tabs and liquid)
fluvoxamine (Luvox)	fluoxetine (Sarafem)
paroxetine (Paxil, Paxil CR, Pexeva)	fluoxetine — 10mg & 20mg Tablets & 40mg Capsules
sertraline (Zoloft)	fluoxetine (Prozac Weekly)
Dual Acting Antidepressants	
Tier-1 (no PA required)	Tier-2 (requires PA)
bupropion (Wellbutrin, Wellbutrin SR, Wellbutrin XL)	duloxetine (Cymbalta)
mirtazapine (Remeron, Remeron Soltab)	nefazodone (Serzone)
trazodone (Desyrel)	venlafaxine (Effexor, Effexor XR)
Monoamine Oxidase Inhibitors	
Tier-1 (no PA required)	Tier-2 (requires PA)
	phenelzine (Nardil)
	tranylcypromine (Parnate)

## Oklahoma Medicaid Prior Authorization Medication Tiers

Angiotensin Converting Enzyme Inhibitors (ACE Inhibitors)	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results or adverse effect, or</li> <li>Documented contraindication to the Tier-1 medications, or</li> <li>Documented FDA-approved indication for which Tier-1 products are not indicated</li> </ul>	
Tier-1 (no PA required)	Tier-2 (requires PA)
benazepril (Lotensin)	moexipril (Univasc)
captopril (Capoten)	perindopril erbumine (Aceon)
enalapril (Vasotec)	ramipril (Altace)
enalaprilat (Vasotec IV)	trandolapril (Mavik)
fosinopril (Monopril)	
lisinopril (Prinivil, Zestril)	
quinapril (Accupril)	

ACE Inhibitor / HCTZ Combinations	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results or adverse effect, or</li> <li>Documented contraindication to the Tier-1 medications, or</li> <li>Documented FDA-approved indication for which Tier-1 products are not indicated</li> </ul>	
Tier-1 (no PA required)	Tier-2 (requires PA)
benazepril/HCTZ (Lotensin HCT)	moexipril/HCTZ (Uniretic)
captopril/HCTZ (Capozide)	quinapril/HCTZ (Accuretic)
enalapril/HCTZ (Vasoretic)	
fosinopril/HCTZ (Monopril HCT)	
lisinopril/HCTZ (Prinzide, Zestoretic)	

ACE Inhibitor / Calcium Channel Blocker Combinations	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results or adverse effect, or</li> <li>Documented contraindication to the Tier-1 medications, or</li> <li>Documented FDA-approved indication for which Tier-1 products are not indicated</li> </ul>	
Tier-1 (no PA required)	Tier-2 (requires PA)
trandolapril / verapamil (Tarka)	benazepril / amlodipine (Lotrel)
	enalapril / felodipine (Lexxel)

Updated 12/6/06

## Oklahoma Medicaid Prior Authorization Medication Tiers

Calcium Channel Blockers (CCB medications)	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p style="text-align: center;"><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results or adverse effect, or</li> <li>Documented contraindication to the Tier-1 medications, or</li> <li>Documented FDA-approved indication for which Tier-1 products are not indicated</li> </ul>	
**Caduet authorization requires FDA-approved indications for both amlodipine and atorvastatin.	
Tier-1 (no PA required)	Tier-2 (requires PA)
diltiazem (Cardizem)	amlodipine (Norvasc)
diltiazem (Tiazac, Taztia XT)	amlodipine/atorvastatin (Caduet)**
diltiazem CD (Cardizem CD)	bepidil (Vascor)
diltiazem ER (Cartia XT, Diltia XT)	diltiazem (Cardizem LA)
diltiazem SR (Cardizem SR)	isradipine (Dynacirc)
diltiazem XR (Dilacor XR)	nicardipine (Cardene SR)
felodipine (Plendil)	nimodipine (Nimotop)
isradipine (Dynacirc CR)	nisoldipine (Sular)
nicardipine (Cardene)	verapamil (Covera HS)
nifedipine (Adalat, Procardia)	verapamil (Verelan PM)
nifedipine CC (Adalat CC)	
nifedipine ER	
nifedipine XL (Nifedical XL, Procardia XL)	
verapamil (Calan, Isoptin, Verelan)	
verapamil SR (Calan SR, Isoptin SR)	

Fibric Acid Derivatives	
<ul style="list-style-type: none"> <li>Tier-1 products are covered with no authorization necessary.</li> </ul>	
<p style="text-align: center;"><u>Tier-2 authorization requires:</u></p> <ul style="list-style-type: none"> <li>Documented trial of a Tier-1 medication with inadequate results or adverse effect, or</li> <li>Documented contraindication to the Tier-1 medications, or</li> <li>Documented FDA-approved indication for which Tier-1 products are not indicated</li> </ul>	
Tier-1 (no PA required)	Tier-2 (requires PA)
clofibrate (Atromid-S)	micronized fenofibrates (Antara)
fenofibrates (Triglide)	
gemfibrozil (Lopid)	
micronized fenofibrates (Lofibra, Tricor)	

## Skeletal Muscle Relaxants

- Tier-1 products are covered with no authorization necessary.

### Tier-2 authorization requires:

- Documented trial of two Tier-1 medications within the last 90 days with no beneficial response after a minimum of 2 weeks of continuous therapy during which time the medication has been titrated to the recommended dose

Tier-1 (no PA required)	Tier-2 (requires PA)
Cyclobenzaprine (Flexeril <sup>®</sup> )	Metaxolone (Skelaxin <sup>®</sup> )
Baclofen (Lioresal <sup>®</sup> )	
Tizanidine (Zanaflex <sup>®</sup> )	
Methocarbamol (Robaxin <sup>®</sup> )	
Chlorzoxazone (Parafon Forte <sup>®</sup> , Paraflex <sup>®</sup> )	
Orphenadrine (Norflex <sup>®</sup> )	

\*Branded products are subject to the Brand Name Override where generic is available.

## ARBs (Angiotensin Receptor Blockers)

- Tier-1 products are covered with no authorization necessary.
- Tier-2 authorization requires one trial with a Tier-1 ACE Inhibitor.

Tier-1 ACE Inhibitors	Tier-2 ARBs (requires PA)
benazepril (Lotensin)	candesartan (Atacand)
captopril (Capoten)	candesartan / HCTZ (Atacand HCT)
enalapril (Vasotec)	iresartan (Avapro)
enalaprilat (Vasotec IV)	olmesartan (Benicar)
fosinopril (Monopril)	losartan (Cozaar)
lisinopril (Prinivil, Zestril)	valsartan (Diovan)
quinapril (Accupril)	valsartan / HCTZ (Diovan HCT)
	losartan / HCTZ (Hyzaar)
	telmisartan (Micardis)
	telmisartan / HCTZ (Micardis HCT)
	eprosartan (Teveten)
	eprosartan / HCTZ (Teveten HCT)

**The ARBs listed below are covered with no PA required**

irbesartan / HCTZ (Avalide)

**Universal Petition for Medication Authroization(1 page)**

This is the standard form used for requesting general authorization of a medication. This form must sometimes be completed with other request forms such as Growth Hormone & Xolair authorization requests.



# 5

## **Medication Therapy Management Services form(2 pages)**

This is a 2-page request used for member on Waiver programs who are permitted up to 13 fills or punches per month. This 2-page request is submitted when the Waiver member has reached their script limit(s) for the month.



MEDICATION THERAPY MANAGEMENT SERVICES—MEMBER REFERRAL FORM

PART 1 — WAIVER VERIFICATION

Is the member enrolled in an Oklahoma Medicaid waiver program?  Yes  No

IF NO, STOP HERE.—The member is not eligible for Medication Therapy Management Services.

(To check a member's waiver status, please contact the OHCA Pharmacy Help Desk at (800) 522-0114, option 4 or (405) 522-6205, option 4.)

PART 2 — MEMBER INFORMATION

Member Name:  Member ID Number:  Date of Birth:  /  /

Is the member known to be allergic to any medications?  Yes  No

If yes, please list:

PART 3 — MEDICATION PROFILE

Complete all information for each line. Include all medications the member is taking, including known OTC products.

	Medication Name / Strength	Regimen	Prescribing Physician	Diagnosis
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				
11)				

(If necessary, additional pages may be attached. Please include member name, ID number, and date of birth on all pages submitted.)

Please provide the requested information and return to:

University of Oklahoma College of Pharmacy  
 Pharmacy Management Consultants  
 Medication Therapy Management Services  
 PO Box 26901, ORI W-4403  
 Oklahoma City, OK 73190

Fax  
 OKC Metro: (405) 271-6002 OKC Metro: (405) 271-6020  
 Toll Free: (866) 335-3331 Toll Free (866) 837-6450

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**Quantity Limit/High Dose override form.(1page)**

This form must be completed when the member is requiring a fill that exceeds the units per day restriction that Oklahoma Medicaid and/or the FDA has set on the medication.

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY  
**Statement of Medical Necessity for Quantity Limit or High Dose Override**

Pharmacy Management Consultants  
Prior Authorization Unit

Phone: 405-522-6205 Opt 4 or 1-800-522-0114 Opt 4  
Fax: 405-271-4014 or 800-224-4014

After completing this form, please **fax** this form and any requested documentation to Pharmacy Management Consultants. Please make sure that the member ID Number is on every page faxed.

**THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:**

Patient's Name:	Member ID Number:
Patient's Date of Birth:	Dispensing Pharmacy Phone Number: (            )            -
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number: (            )            -
Dispensing Pharmacy OHCA Provider Number:	Drug Name & Strength:
Drug NDC Number:	Requested Rx Fill Quantity & Days' Supply:
Drug Dosing Regimen:	Drug Fill Date:
Prescriber Name:	OHCA 7-digit Prescriber Number:
Prescriber Phone Number:	Prescriber Fax Number:

**THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:**

**DRUG QUANTITY LIMIT OR HIGH DOSE OVERRIDE**

1. Specific diagnosis: \_\_\_\_\_

2. Detailed description of reason patient needs a greater quantity or dose greater than FDA recommends: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. If dosing is weight-based or body surface area-based:  
Patient's Weight: \_\_\_\_\_  
Patient's Height: \_\_\_\_\_

**\*\* OHCA may request additional supporting documentation.**

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)  
A list of Medicaid quantity limits may be found at the following Oklahoma Health Care Authority website:  
<http://www.okhca.org>

**Early Fill override form(1 page)**

This form must be completed when the member is needing their medication refilled earlier than anticipated due to dosage increase, lost, stolen or damaged medication or other such circumstances.

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY  
**Statement of Medical Necessity for Early Fill Override**

Pharmacy Management Consultants  
Prior Authorization Unit

Phone: 405-522-6205 Opt 4 or 1-800-522-0114 Opt 4  
Fax: 405-271-4014 or 800-224-4014

**THIS FORM IS TO BE COMPLETED BY THE PHARMACY**

After completing this form, please **fax** this form and any requested documentation to Pharmacy Management Consultants. Please make sure that the member's ID Number is on every page faxed.

Patient's Name:	Member ID Number:
Patient's Date of Birth:	Dispensing Pharmacy Phone Number: (            )            -
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number: (            )            -
Dispensing Pharmacy OHCA Provider Number:	Drug Name & Strength:
Drug NDC Number:	Requested Rx Fill Quantity & Day's Supply:
Drug Dosing Regimen - Current:	Requested Drug Fill Date:
Prescriber Name:	OHCA 7-digit Prescriber Number:
Prescriber Phone Number:	Prescriber Fax Number:

**EARLY FILL OVERRIDE**

**Patient needs early fill because:**

**Dosage Change**

Previous dosing regimen: \_\_\_\_\_ Previous fill date (if known) \_\_\_\_\_

**Lost, broken, spilled, or wasted medication**

Please explain: \_\_\_\_\_

If medication is a schedule 2 drug and it was lost in a fire, please send a copy of the police report. Please make sure that the member ID Number is on every page faxed.

**Stolen medication**

If medication is a schedule 2 drug and it was stolen, please send a copy of the police report. Please make sure that the member ID Number is on every page faxed.

**Wrong days' supply on a previous Rx**

**Other (please explain):** \_\_\_\_\_

\_\_\_\_\_

**\*\* OHCA may request additional supporting documentation.**

**Pharmacist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(With this signature, the pharmacist confirms that the information above is accurate and verifiable in patient records.)**

# 8

## **Brand-Name Drug override form(2-pages)**

This form must be completed when the member is needing a Brand Name medication with an available generic on the market. This is a 2-page form that must be completed with information from the physician stating in detail why the member cannot have the generic of the requested medication.

Please note: This form **cannot** be used to override a person's 3 Brand Name prescription limit.

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY  
**Statement of Medical Necessity for Brand-Name Drug Override**

Pharmacy Management Consultants  
Prior Authorization Unit

Phone: 405-271-6349 or 1-800-831-8921  
Fax: 405-271-4014 or 800-224-4014

After completing this form, please fax this form and any requested documentation to Pharmacy Management Consultants.  
Please make sure that the client's Medicaid ID Number is on every page faxed.

**THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:**

Patient's Name:	Patient's Medicaid Client ID Number:
Patient's Date of Birth:	Dispensing Pharmacy Phone Number: (        ) -
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number: (        ) -
Dispensing Pharmacy OHCA Provider Number:	Requested Drug Name & Strength:
Requested Drug NDC Number:	Requested Drug Monthly Quantity:
Requested Drug Dosing Regimen:	Requested Drug Fill Date:
Prescriber Name:	Medicaid Prescriber Number:
Prescriber Phone Number:	Prescriber Fax Number:

**THIS SECTION MUST BE COMPLETED AND SIGNED BY THE PRESCRIBER:**

**Patient needs the requested brand-name drug rather than its FDA approved generic equivalent because:**

- Patient experienced an adverse event while using the generic medication.
- The generic medication was not effective for the patient.
- Other (Please explain): \_\_\_\_\_

**Please answer the following questions about what happened when the patient took the generic medication:**

**1. Generic medication taken (Give labeled strength, mfr/labeler, lot #, & exp. date, if known):**

\_\_\_\_\_

\_\_\_\_\_

**2. Dose, frequency, & route used:**

\_\_\_\_\_

**3. Date(s) patient took the generic medication (give from/to or best estimate):**

\_\_\_\_\_

\_\_\_\_\_

**4. Diagnosis for use:**

\_\_\_\_\_

Statement of Medical Necessity for Brand-Name Drug Override

Patient's Medicaid Client  
ID Number (REQUIRED):

5. Description of adverse event or problem:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. How long after beginning use of drug did the event occur?

\_\_\_\_\_

7. Outcomes attributed to adverse event caused by generic medication:

- Life-threatening     Hospitalization – initial or prolonged     Disability
- Intervention was required to prevent permanent impairment/damage
- Other: \_\_\_\_\_

8. Event abated after use stopped or dose reduced?     Yes     No     Doesn't apply  
If yes, how long after stopping or reducing dose of drug did event abate?

\_\_\_\_\_

9. Event reappeared after reintroduction?     Yes     No     Doesn't apply

10. Concomitant medical products & therapy dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

11. Relevant Tests/Laboratory Data, Including Dates: \_\_\_\_\_

\_\_\_\_\_

12. Other Relevant History, Including Preexisting Medical Conditions (e.g., allergies, race, pregnancy, smoking and alcohol use, hepatic/renal dysfunction, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. Patient's drug/excipient allergies:

\_\_\_\_\_

14. Patient's Weight: \_\_\_\_\_

15. Patient's Height: \_\_\_\_\_

**\*\* Medicaid may request additional supporting documentation.\*\***

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)

**Synagis petition(1page)**

This petition must be completed when the member is requiring the medication Synagis. Authorization of this medication is approved only part of the year and requires detailed information from the physician.

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY  
PETITION FOR SYNAGIS AUTHORIZATION

Member Name: \_\_\_\_\_ Sex: \_\_\_\_\_ UCI: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Gestational age: \_\_\_\_\_ weeks Current Age: \_\_\_\_\_ Months  
Birth Weight: \_\_\_\_\_ lb/kg Current Weight: \_\_\_\_\_ lb/kg Date Recorded: \_\_\_\_\_

**DRUG INFORMATION:** 15 mg/kg IM. Only those doses that require greater than a vial's dose +10% may use the next vial size or an additional vial (e.g. 1-55 mg = 50 mg vial, 56-110 mg = 100 mg vial). The maximum duration of therapy is 6 doses with 1 dose given every 30 days.

Physician billing  CPT code 90378 (50 mg/unit)  
Pharmacy billing  50 mg/0.5 ml: NDC: **60574411401**  100 mg/ml: NDC: **60574411301**

**PROVIDER INFORMATION:**  Pharmacy  Physician  
Provider \_\_\_\_\_ OHCA Provider Billing ID# \_\_\_\_\_  
Provider Phone: \_\_\_\_\_ Provider Fax: \_\_\_\_\_  
Prescriber \_\_\_\_\_ OHCA Prescriber ID# \_\_\_\_\_

**CRITERIA**

Member must be included in one of the following age groups at the beginning of the RSV season:

- Infants and children less than 24 months old with Chronic Lung Disease (CLD) (formerly broncho-pulmonary dysplasia) who have required medical treatment (O<sub>2</sub>, bronchodilator, diuretic, or corticosteroid therapy) for CLD in the 6 months prior to RSV season. Treatment/date received: \_\_\_\_\_
- Infants less than 12 months of age, born at 28 weeks gestation or earlier
- Infants less than 6 months of age, born at 29-32 weeks gestation.
- Infants, up to 6 months old, born at 32-36 weeks gestation, who have 2 or more of the following risk factors:
  - Child care attendance
  - School-aged siblings
  - Exposure to environmental air pollutants (Tobacco smoke exposure is NOT considered a risk factor since this can be controlled by the family) Describe: \_\_\_\_\_
  - Congenital abnormalities of the airway
  - Severe neuromuscular disease
- Children up to 24 months old with hemodynamically significant cyanotic and acyanotic congenital heart disease.
- Infants up to 12 months old with moderate to severe pulmonary hypertension, cyanotic heart disease, or those on medications to control congestive heart failure.

Additional Information: \_\_\_\_\_

Prescriber Signature (*Required*) \_\_\_\_\_ Date \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please Provide the Information Requested and Return to:**

UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY  
PHARMACY MANAGEMENT CONSULTANTS  
PRODUCT BASED PRIOR AUTHORIZATION UNIT  
**PO BOX 26901; ORI W-4403**  
OKLAHOMA CITY, OKLAHOMA 73190

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

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

CONFIDENTIALITY NOTICE: 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.

**Growth Hormone petition(2 pages)**

This form must be completed along with the Universal Authorization form when the member is requiring authorization of any covered growth hormone medication.

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY  
**PETITION FOR GROWTH HORMONE THERAPY AUTHORIZATION**

ONLY ONE INDIVIDUAL PER PETITION

Client Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

UCI: \_\_\_\_\_

**TO BE COMPLETED BY DISPENSING PHARMACY**

Dispensing Pharmacy Name: \_\_\_\_\_

Dispensing Pharmacy OHCA Provider Number: \_\_\_\_\_

Dispensing Pharmacy Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

NDC Number: \_\_\_\_\_

**TO BE COMPLETED BY PRESCRIBING PHYSICIAN**

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Volume Prescribed: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Height - Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Child Target: \_\_\_\_\_

Please list Growth Hormone Stimulation tests and pharmacological stimulation tests and the results that were used to confirm diagnosis: \_\_\_\_\_

Please list recent dates and corresponding measurements for Chronological age, Bone Age, Growth Velocity and Height:

Date	Chrono. Age	Date	Bone Age	Date	Growth Velocity	Date	Height
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Intent of the Program is to work with Health Care Providers. Therefore, if there are circumstances relating to the treatment of the individual that would warrant additional consideration, please provide appropriate comments on an additional page.

Signature of Prescribing Physician: \_\_\_\_\_

Name of Prescribing Physician (Please Print): \_\_\_\_\_

Prescribing Physician's Phone Number: \_\_\_\_\_

Please Provide the Information Requested and Return to:  
UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY  
PHARMACY MANAGEMENT CONSULTANTS  
PRODUCT BASED PRIOR AUTHORIZATION UNIT  
PO BOX 26901; ORI W-4403  
OKLAHOMA CITY, OKLAHOMA 73190

Phone (405) 552-6205 Opt 4  
Toll Free 1-800-522-0114 Opt 4

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



**Tuberculosis petition(1 page)**

This form must be completed when the member is needing authorization of a medication specifically used for the treatment of tuberculosis.

STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY  
**PETITION FOR TUBERCULOSIS (TB) RELATED THERAPY AUTHORIZATION**

ONLY ONE INDIVIDUAL PER PETITION

Client Name: \_\_\_\_\_ Birthdate:   /   /

UCI:

**TO BE COMPLETED BY DISPENSING PHARMACY**

Dispensing Pharmacy Name: \_\_\_\_\_

Dispensing Pharmacy OHCA Provider Number:

Dispensing Pharmacy Phone Number: \_\_\_\_\_ Dispensing Pharmacy Fax Number: \_\_\_\_\_  
(    )   -    (    )   -

NDC Number:      -     -

**TO BE COMPLETED BY PRESCRIBING PHYSICIAN**

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Qty Prescribed: \_\_\_\_\_

Has the patient been approved for TB benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list supporting information that associates this therapy with the patient's primary diagnosis of TB (use additional sheets if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Intent of the Program is to work with Health Care Providers. Therefore, if there are circumstances relating to the treatment of the individual that would warrant additional consideration, please provide appropriate comments on an additional page.

Signature of Prescribing Physician: \_\_\_\_\_

Name of Prescribing Physician (Please Print): \_\_\_\_\_

Prescribing Physician's Phone Number: (    )   -

Please Provide the Information Requested and Return to:  
UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY  
PHARMACY MANAGEMENT CONSULTANTS  
PRODUCT BASED PRIOR AUTHORIZATION UNIT  
PO BOX 26901; ORI W-4403  
OKLAHOMA CITY, OKLAHOMA 73190

Phone (405) 522-6205 Opt 4      FAX (405) 271-4014  
Toll Free 1-800-522-0114 Opt 4      Toll Free 1-800-224-4014

**Xolair petition(2 pages)**

This form must be completed along with a Universal Authorization form when the member is requiring authorization of the medication Xolair.





**Manual Pharmacy Claim form w/ instructions(3 pages)**

This must be completed anytime a member's medication claims cannot be filed electronically whether it is due to the fact that the claims to be filed are too old or other possible reasons.



# Pharmacy Drug Claim Form

## Required Data Elements

- 12. Prescription Number – 7 characters
- 13. Date Prescribed – on or before receipt date, not a future date
- 14. Date Dispensed – on or before receipt date, cannot be future date
- 15. NDC Number – numeric, 11 digits
- 16. Metric Quantity – decimal and 3 zeros after value, up to 11 characters. Example: 99999999.999
- 17. Days Supply – up to 3 characters
- 18. Charge – numeric, up to 9 digits
- 19. TPL paid – numeric, eight digits, required if applicable
- 21. Signature of Provider or Representative
- 22. Date Billed/Date of Claim Submission

SAMPLE

PLEASE PRINT CLEARLY

Provider Number		Loc	Telephone Number		Total Amount Billed		<b>DRUG CLAIM FORM</b>														
01		02		03		04		05		06		07		08		09		10		11	
PATIENT'S NAME: LAST, FIRST XXXXXXXX, XXXXXX X				CLIENT NO. XXXXXXXXXX		PRESCRIBER'S I.D. NUMBER XXXXXXXX		EMERG X	PREG X	N.H.PAT. X	BRAND X	REFILL XX									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER XXXXXXX		DATE PRESC XX/XX/XXXX		DATE DISP XX/XX/XXXX		NDC NUMBER XXXXXXXXXX		QTY X.XXX		DAYS XXX		CHARGE XXXXXXXXXX		3 <sup>RD</sup> PT PAID XXXXXXX							
1 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							
2 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							
3 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							
4 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							
5 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							
6 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							
7 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							
8 PATIENT'S NAME: LAST, FIRST				13 CLIENT NO.		15 PRESCRIBER'S I.D. NUMBER		17 EMERG	18 PREG	19 N.H.PAT.	20 BRAND	21 REFILL									
12		13		14		15		16		17		18		19		20		21		22	
PRESCRIPTION NUMBER		DATE PRESC		DATE DISP		NDC NUMBER		QTY		DAYS		CHARGE		3 <sup>RD</sup> PT PAID							

18 Provider's Name and Address

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of Provider or Representative \_\_\_\_\_ Date Billed \_\_\_\_\_

19 XXXXXXXX X. XXXXXXXXX 20 XX/XX/XXXX

MAIL COMPLETED CLAIM FORM TO:  
P.O. Box 18650  
Oklahoma City, OK 73154

HCA-10  
Issued 01/01/2003

Oklahoma Health Care Authority

**PLEASE PRINT CLEARLY**

01 Provider Number		02 Loc		03 Telephone Number		Total Amount Billed						
0	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
1	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
2	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
3	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
4	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
5	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
6	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
7	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	
8	PATIENT'S NAME: LAST, FIRST			CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H.PAT.	BRAND	REFILL
	04	05	06	07	08	09	10	11	3 <sup>RD</sup> PTY PAID			
12	PRESCRIPTION NUMBER		DATE PRESC	DATE DISP	NDC NUMBER		QTY	DAYS	CHARGE		3 <sup>RD</sup> PTY PAID	

Provider's Name and Address

18

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I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of  
Provider or Representative

Date Billed

19

20

MAIL COMPLETED CLAIM FORM TO:

EDS  
P.O. Box 18650  
Oklahoma City, OK 73154

**Manual Compound Claim form w/ instructions(3 pages)**

This must be completed anytime a member's Compounded medication claims cannot be filed electronically whether it is due to the fact that the claims to be filed are too old or other possible reasons.

# Compound Prescription Drug Claim Form

## Required Data Elements

1. Provider Number – 10 digits, last digit is location code

3. Patient's Name – Last, First

4. Client ID Number – 9 digits

5. Prescriber ID Number – 7 digits

6. Emergency Ind. – Yes or No, if applicable

7. Pregnancy Ind. – Yes or No, if applicable

8. Nursing Home Ind. – Yes or No, if applicable

9. Brand BMN Ind. 0 – no product selection indicated  
1 – substitution not allowed by

10. Refill Indicator – two digit field, if single digit, plug zero plus value. Example: 00 = original dispensing, 01 to 99 =

SAMPLE

PLEASE PRINT CLEARLY

Provider Number		Loc	Telephone Number	<b>COMPOUND PRESCRIPTION DRUG CLAIM FORM</b>										
XXXXXXXXXX		X		PATIENT'S NAME: LAST, FIRST		CLIENT NO.	PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H. PAT	BRAND	REFILL	
XXXXXXXXXX, XXXXXX X				XXXXXXXXXX		XXXXXXXXXX	XXXXXXXXXX		X	X	X	X	XX	
PRESCRIPTION NUMBER		DATE PRESCRIBED		DATE DISPENSED		LOC	USE ONLY	DAYS	CHAR	PARTIAL		QUANTITY		
XXXXXXXXXX		XX / XX / XXXX		XX / XX / XXXX				XXX	XXXXXXX	X		XXXXXX		
11	12	13	14	15	16	17	18	19	20	21	22	23	24	
NAME		ADDRESS		DESCRIPTION OF INGREDIENT										
NUMBER	1		XXXXXXXXXXXXX											
NUMBER	2													
NUMBER	3													
NUMBER	4													
NUMBER	5													
NUMBER	6													
NUMBER	7													
NUMBER	8													
NUMBER	9													
NUMBER	10													
NUMBER	11													
NUMBER	12													
NUMBER	13													
NUMBER	14													
NUMBER	15													
Provider's Name and Address				<p>This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.</p> <p>I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.</p>										
18				Signature of Provider or Representative					Date Billed					
				19 XXXXXXXX X. XXXXXXXXXXXXX					20 XX / XX / XXXX					
MAIL COMPLETED CLAIM FORM TO:														
EDS P.O. Box 18650 Oklahoma City, OK 73154 HCA-11 Issued 1-1-03														

# Compound Prescription Drug Claim Form

## Required Data Elements

11. Prescription Number – 7 characters

12. Date Prescribed – must be on or before receipt date, cannot be a future date

13. Date Dispensed – must be on or before receipt date, cannot be a future date

15. Days Supply – up to 3 characters

16. Charge – numeric, up to nine digits

17. TPL Paid – numeric, up to eight digits

19. Signature of Provider or Representative

20. Date Billed/Date of Claim Submission – must be on or before receipt date, no future date

21. NDC Number – numeric, 11 digits

23. Metric Unit Quantity – Example: 9999999.999

SAMPLE

PLEASE PRINT CLEARLY

Provider Number XXXXXXXXXX		Loc X	Telephone Number	<b>COMPOUND PRESCRIPTION DRUG CLAIM FORM</b>						
PATIENT'S NAME: LAST, FIC XXXXXXXXXX, XXXXXX		CLIENT NO. XXXXXXXXXX	PREScriBER'S I.D. NUMBER XXXXXXX	EMERG X	PREG X	N.H. PAT X	BRAND X	REFILL XX		
PREScription NUMBER XXXXXXX	DATE PRESCRIBED XX/XX/XXXX	DATE DISPENSED XX/XX/XXXX	LOCAL USE ONLY	DAYS XXX	CHARGE XXXXXXX	3 <sup>rd</sup> PARTY PAID XXXXXXXXXX				
LINE NUMBER	NDC NUMBER	DESCRIPTION OF INGREDIENT						QUANTITY		
1	XXXXXXXXXX							X.XXX		
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										

18. Provider's Name and Address

19. Signature of Provider or Representative

20. Date Billed

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

MAIL COMPLETED CLAIM FORM TO:  
 EDS  
 P.O. Box 18650  
 Oklahoma City, OK 73154  
 HCA-11  
 Issued 1-1-03

Oklahoma Health Care Authority



PLEASE PRINT CLEARLY

1 Provider Number		Loc	Telephone Number								
3 PATIENT'S NAME: LAST, FIRST			2 CLIENT NO.		PRESCRIBER'S I.D. NUMBER		EMERG	PREG	N.H. PAT	BRAND	REFILL
3 PRESCRIPTION NUMBER		DATE PRESCRIBED	4 DATE DISPENSED		5 LOCAL USE ONLY	DAYS	6 CHARGE		3 <sup>RD</sup> PARTY PAID		
11 LINE NUMBER	21 NDC NUMBER		22 DESCRIPTION OF INGREDIENT					17 QUANTITY			
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Provider's Name and Address

18

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any falsification of claims, statements, or documents, or concealment of material fact may be prosecuted under applicable Federal or State law.

I, the undersigned, being aware of restricted funds in the Medicaid program, agree to accept as full payment for services enumerated on this claim form, for this Medicaid patient, the allowance determined by the Department or its designee. I further certify that no supplemental charges have been or will be billed to the patient; I further recognize that any difference of opinion concerning the charges and/or allowance for this claim shall be adjudicated as specified in the Provider Manual.

Signature of  
Provider or Representative

19

Date Billed

20

MAIL COMPLETED CLAIM FORM TO:

EDS  
P.O. Box 18650  
Oklahoma City, OK 73154

**The medication fill process (1page)**

This is simply the standard procedure for members needing medications paid for through SoonerCare/Medicaid

## **Medication Prescription Fill Process**

- >Prescription(s) written & taken or called into pharmacy.
- >Eligibility verified if necessary by Rx calling Help Desk.
- >Claims processing attempted . . .
  - \* if claim processing succeeds medication is dispensed.
  - \* if claim denies the pharmacy contacts us for reason and/or solution.
  - \* if authorization of any kind is necessary the pharmacy completes their portion of the appropriate request form(s) and faxes to the doctor office where the script originated. The doctor office completes the form(s) & faxes to us for review.
- >After the pharmacists at Pharmacy Management Consultants review the request(s), the response is faxed back to the requesting pharmacy. If the request has been Approved the claims should pay and the medication should be dispensed. If the request is Disapproved, the pharmacy relays the reason for disapproval to the doctor office where the script originated.

## **Compound billing tips (1page)**

This lists the general rules to follow when billing Compound claims to SoonerCare/Medicaid.

# Compound Billing Tips

4/26/06

- a) **A compound claim should have more than one NDC# listed on it, otherwise it is just a single item Pharmacy claim.**
- b) **All NDC's of the compound should be included on the claim.**
- c) **If any part of the compound needs a PA, that must first be authorized before the compound can be billed to Medicaid.**
- d) **Medicaid covered products should be listed first; if not done so the claim may pay but might only reimburse \$4.15.**
- e) **If any NDC of the compound is covered the claim will not deny & the Rx will be reimbursed for the covered portion of the compound.**
- f) **There is no special compound billing dispensing fee paid to the Rx, only the standard \$4.15 dispensing fee for each compound claim.**
- g) **The Rx can only charge the member for the products that are not covered by Medicaid plus any \$1 or \$2 copay that may apply.**