oklahoma complete health

Prior Authorization Request Form for All Prescription Medications

CoverMyMeds is the preferred way to submit this form. **https://www.covermymeds.com/main/prior-authorization-forms/**
OR FAX completed form to 1-844-235-5092
OR MAIL requests to: Centene Pharmacy Services Coverage Determinations| P.O. Box 31397 |Tampa, FL 33631-3397
OR CALL 1-833-331-1515 (SoonerSelect) or 1-833-655-0896 (SoonerSelect Children's Specialty Program)

I. PROVIDER INFORMATION	**II. MEMBER INFORMATION**
Prescriber name:	Member name:
Form Submitter name:	Member ID#
Provider NPI:	Group number (optional):
Fax:	Date of Birth:
Phone:	Relevant allergies (if any):

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage form:	Dosage Interval (sig):	Qty per Day:
Diagnosis(es) relevant to this request:			
Expected length of therapy:			

Medication History for this Diagnosis

A. Is member currently treated on this medication?

☐ yes, How Long?_____[go to item B] ☐ no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?

☐ yes [go to item C] ☐ no / unknown [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?

☐ yes [go to item D] ☐ no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below

Drug Name (include strength and dosing)	**Dates of Therapy**	**Reason for Discontinuation**
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The Oklahoma Complete Health Formulary is available on their website at **https://www.oklahomacompletehealth.com/providers/pharmacy.html.**

IV. RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION (Required for all Prior Authorizations)

Appropriate clinical information to support the request based on medical necessity must be attached.	Submitter Signature:	Date:

Pharmacy Services will respond via fax or phone within 24 hours of receipt. Requests for prior authorization (PA) must include member name and ID#, and drug name. **Incomplete forms will delay processing.** Please attach lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.) For additional questions or to expedite this request, please call numbers listed above.