

## 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			
<b>A. Is member currently treated on this medication?</b> <input type="checkbox"/> yes, How Long? _____ [go to item B] <input type="checkbox"/> no [skip items B & C; go to item D]			
<b>B. Is this request for continuation of a previous approval?</b> <input type="checkbox"/> yes [go to item C] <input type="checkbox"/> no / unknown [skip item C; go to item D]			
<b>C. Has strength, dosage, or quantity required per day increased or decreased?</b> <input type="checkbox"/> yes [go to item D] <input type="checkbox"/> no [skip item D; indicate rationale for continuation in Section IV and submit form]			
<b>D. Please indicate previous treatment and outcomes below</b>			
Drug Name (include strength and dosing)	Dates of Therapy	Reason for Discontinuation	
1			
2			
3			
4			
<b>NOTE:</b> 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 <a href="https://www.oklahomacompletehealth.com/providers/pharmacy.html">https://www.oklahomacompletehealth.com/providers/pharmacy.html</a> .			
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.