Oklahoma HealthCare Authority

Statement of Medical Necessity for Ingredient Duplication Override

Pharmacy Management Consultants - Prior Authorization
Unit Phone: 405-522-6205 or 1-800-522-0114 option 4
Fax: 405-271-4014 or 1-800-224-4014

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

THIS SECTION IS TO BE COMPLETED BY THE PHARMACY:

Member's Name:	Member's ID Number:
Member's Date of Birth:	Dispensing Pharmacy Phone Number: ( ) -
Dispensing Pharmacy Name:	Dispensing Pharmacy Fax Number: ( ) -
Dispensing Pharmacy NPI:	Requested Drug NDC Number:
Prescriber Name:	Prescriber NPI:
Prescriber Phone Number:	Prescriber Fax Number:

Previous Fill	**Requested Fill**
Hydrocodone strength: Regimen: Fill Date: Day Supply: Quantity: Prescriber Name:	Hydrocodone strength: Regimen: Fill Date: Day Supply: Quantity:

THIS SECTION MUST BE COMPLETED AND SIGNED BY THE

PRESCRIBER: Ingredient Duplication Override

1. Specific diagnosis: _____

2. Detailed description of reason patient needs a different strength of the same medication/ or change to different physician:

_____

_____

_____

SoonerCare 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.)