

**PETITION FOR TUBERCULOSIS (TB) RELATED THERAPY  
AUTHORIZATION**

ONLY ONE INDIVIDUAL PER PETITION

Member Name: \_\_\_\_\_ Birthdate: 

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Member ID: 

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**TO BE COMPLETED BY DISPENSING PHARMACY**

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

Dispensing Pharmacy NPI: 

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Dispensing Pharmacy Phone Number: ( 

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 Dispensing Pharmacy Fax Number: ( 

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NDC Number: 

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**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 the additional page.

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

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

Prescribing Physician's Fax Number: ( 

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Prescribing Physician's NPI: 

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Please Provide the Information Requested and Return to: UNIVERSITY OF OKLAHOMA  
COLLEGE OF PHARMACY  
PHARMACY MANAGEMENT CONSULTANTS PRODUCT BASED PRIOR  
AUTHORIZATION UNIT