STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

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 (i.e. the member is not eligible for Medication Therapy Management Services. Call 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? If ☐ *Yes* ☐ *No*

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

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

Phone
OKC Metro: (405) 271-6020
Toll Free (866) 837-6450