

MEDICATION THERAPY MANAGEMENT SERVICES—MEMBER REFERRAL FORM

**PART 1 — WAIVER**

**VERIFICATION** Is the member enrolled in an Oklahoma Medicaid waiver program?  Yes  No

**No** \_\_\_\_\_

**IF NO, STOP HERE.** The member is not eligible for Medication Therapy Management Services 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

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