OPHP VERIFICATION OF PRESCRIBED MEDICATION
NOTICE TO PRESCRIBING PRACTIONERS

To the practitioner of the Oklahoma Pharmacists Helping Pharmacists Monitoring (OPHP) participant; the individual who is providing this form is a participant in the Oklahoma Board of Pharmacy approved OPHP Monitoring Program. As part of the program, the participant is required to provide documentation of all prescribed medications. **I acknowledge that my patient has informed me that he/she is in recovery or has a substance use disorder and should not take controlled medications or OTC medications with abuse potential that pose a risk to his/her sobriety.**

Please take a few minutes to complete the form below. After completing the form, please fax or mail to the OPHP office. **This form will only be accepted if received directly from the practitioner.** If you have any questions, please call OPHP at the following telephone number: 1-800-260-7574

PRESCRIPTION INFORMATION

Patient's Name____________________________

Date of Prescription	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication
__________	______________	____________________________________	______________________
__________	______________	____________________________________	______________________
__________	______________	____________________________________	______________________
__________	______________	____________________________________	______________________

______________________________________ ____________________________________
Practitioner Signature

____
Name (Please print)

______________________________________ ____
Practitioner Office Address

Date: ______________________ Office Telephone Number: __________________________________

OPHP Address: 3000 E. Memorial Rd, Edmond, OK 73013
OPHP fax: (405) 557-5732

Additional Comments: ____
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