# Hawaii Standardized Prescription Drug Prior Authorization Form*

Request Date: ____________________

## Patient Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Phone Number</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>M/F</td>
<td></td>
</tr>
</tbody>
</table>

Member ID # (if known):

## Provider Information

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Contact Person</th>
<th>Phone Number</th>
<th>Fax Number</th>
<th>Pharmacy</th>
</tr>
</thead>
</table>

Provider Address: ________________________

Timeline: [ ] Routine [ ] Urgent

Pharmacy Phone: ________________________

Pharmacy Fax: ________________________

## Physician Section

Diagnosis or ICD-10 Code: ________________________

Period Requested: ________________________

Prognosis: ________________________

Medication: Name, Strength, Dosage [ ] New [ ] Continuation

Quantity: ________________________

Refills: ________________________

Directions for Use (include dosage and frequency): ________________________

Other Medication Used and Reason for Failure (include approximate dates of trial)

Other Justification ( [ ] Attach all recent or pertinent clinical notes)

Prescriber’s Signature: ________________________

Date: ________________________

## Insurance Plans that Have Agreed to Accept This Form

Check Insurance Box

- [ ] AlohaCare QUEST Integration Fax: 808-973-6327 Phone: 808-973-7418
- [ ] AlohaCare Advantage Plus Medicare Fax: 808-973-6327 Phone: 808-973-7418
- [ ] HMSA QUEST Fax: 1-888-836-0730 Phone: 1-800-294-5979
- [ ] Ohana Health Plan QUEST / QExA Fax: 1-888-877-8239 Phone: 1-866-924-0277
- [ ] Ohana Health Plan Medicare Fax: 1-866-388-1767 Phone: 1-866-924-0277
- [ ] United HealthCare QUEST / QExA Fax: 1-866-940-7328 Direct Call In PA: 1-800-310-6826

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*For Internal Plan use only:

- [ ] Approved Date Approved Through: __________ Refills: _________
- [ ] Not Approved Reason Not Approved: ________________________

Reviewer: ________________________ Date: ________________________

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*Health plans may require additional information or specialized PA form for specialty medications.