

Hawaii Standardized Prescription Drug Prior Authorization Form*

Request Date: _____

Patient Information				
Last Name	First Name	Phone Number	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Member ID # (if known):				
Provider Information				
Provider Name	Contact Person	Phone Number	Fax Number	
Provider Address		Pharmacy		
Timeline <input type="checkbox"/> Routine <input type="checkbox"/> Urgent		Pharmacy Phone: Pharmacy Fax:		
Physician Section				
Diagnosis or ICD-9 Code				
Period Requested		Prognosis		
Medication: Name, Strength, Dosage		<input type="checkbox"/> New <input type="checkbox"/> Continuation	Quantity	Refills
Directions for Use (include dosage and frequency)				
Other Medication Used and Reason for Failure (include approximate dates of trial)				
Other Justification (<input type="checkbox"/> Attach all recent or pertinent clinical notes)				
Prescriber's Signature				Date
Insurance Plans that Have Agreed to Accept This Form				
Check Insurance Box				
<input type="checkbox"/> AlohaCare QUEST Integration		Fax: 808-973-6327	Phone: 808-973-7418	
<input type="checkbox"/> AlohaCare Advantage Medicare: ACA Plus		Fax: 808-973-6327	Phone: 808-973-7418	
<input type="checkbox"/> HMSA QUEST		Fax: 1-888-836-0730	Phone: 1-800-294-5979	
<input type="checkbox"/> Ohana Health Plan QUEST / QExA		Fax: 1-888-877-8239	Phone: 1-866-924-0277	
<input type="checkbox"/> Ohana Health Plan Medicare		Fax: 1-866-388-1767	Phone: 1-866-924-0277	
<input type="checkbox"/> United HealthCare QUEST / QExA		Fax: 1-866-940-7328	Direct Call In PA: 1-800-310-6826	
For Internal Plan use only:				
<input type="checkbox"/> Approved		Date Approved Through: _____		Refills: _____
<input type="checkbox"/> Not Approved		Reason Not Approved: _____		
Reviewer: _____ Date: _____				

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