Hawaii Standardized Prescription Drug Prior Authorization Form*

Request Date:_____

Patient Information				
Last Name	First Name	Phone Number	Gender ☐ M ☐ F	Date of Birth / /
Member ID # (if known):				

Provider Information			
Provider Name	Contact Person	Phone Number	Fax Number
Provider Address		Pharmacy	
Timeline ☐ Routine ☐ Urgent		Pharmacy Phone: Pharmacy Fax:	

Physician Section			
Diagnosis or ICD-9/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

For Internal Plan use only:

Approved Date Approved Through:_____ Refills:_____

Not Approved Reason Not Approved:_____

Reviewer:_____ Date:_____

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