



‘OHANA INJECTABLE INFUSION FORM

Prior Authorization Request for ‘Ohana Medicaid
 FAX to 1 888-877-8239 Pharmacy - Injectable Infusion Department

Requested by : Physician Member Pharmacy

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)						Date Submitted				
Member ID #						Provider ID#				
Name						Name				
Address						Address				
City		State	Zip			City		State	Zip	
Phone			DOB			Contact				
Height	Wt lb/ Kg	Dx				Phone		Fax		
Allergies		ICD9					Alt Phone		Fax	
Medication			Dose			Frequency			Length of Treatment	
Physician Signature: _____										
Clinical Reason for override (Include medications tried and failed, laboratory values, or any other pertinent information). Please fax additional pages as necessary.										
Does the member reside in a long term care facility (LTC) ? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Will the medication be sent to the provider’s office for administration? <input type="checkbox"/> Yes <input type="checkbox"/> No										
If Yes: Pharmacy is responsible for collecting the medication co-payment/co-insurance from the patient. Drugs <u>Will Not</u> be sent until payment is received.										
Send to address listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No Send to:										
Name _____										
Address _____										
City, State, ZIP _____ Phone : _____										
Will physician supply and administer medication in the office ? <input type="checkbox"/> Yes <input type="checkbox"/> No										
If Yes: Physician’s office is responsible for collecting medication co-payment/co-insurance from the patient.										
Is the Medication being administered at the patient’s home? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Is the medication being administered at a facility or outpatient center? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Facility Name/Outpatient Clinic: _____ Facility Name/Outpatient Clinic Provider ID#: _____										