



‘OHANA INJECTABLE INFUSION FORM

Prior Authorization Request for ‘Ohana Medicare
 FAX to 1-866-388-1767 ‘Ohana - Injectable Infusion Department

Who is making this request? Provider Member

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results)	Date Submitted	
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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) ? Yes No

Will the medication be sent to the provider’s office for administration? Yes No

If Yes: Pharmacy is responsible for collecting the medication co-payment/co-insurance from the patient. Drugs Will Not be sent until payment is received.

Send to address listed above? Yes No Send to:

Name _____

Address _____

City, State, ZIP _____ Phone : _____

Will physician supply and administer medication in the office ? Yes 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? Yes No

Is the medication being administered at a facility or outpatient center? Yes No

Facility Name/Outpatient Clinic: _____ Facility Name/Outpatient Clinic Provider ID#: _____

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