Medicaid Drug Coverage Request Form

Instructions: Please use this form to request coverage of a drug that we would not usually cover or would restrict in some way. Please fill out ALL REQUIRED FIELDS of this form. Then fax it to the ʻOhana Pharmacy Department at **1-866-825-2884**.
To see a list of the drugs we cover and rules we have about coverage, please visit us at **www.ohanahealthplan.com**.

If you need help filling out this form, you may ask your doctor or call us at **1-888-846-4262 (TTY 711)**. We're here for you Monday through Friday, 7:45 a.m. to 4:30 p.m. Hawai'i Standard Time.

Who is making this request? Provider ☐ Member ☐ Appointed Representative ☐

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

Complete the following section ONLY if the person making this request is not the Member or prescriber:

Requestor's Name		
Requestor's Relationship to Member		
Address		
City	State	Zip Code
Requestor Phone		

Representation documentation for requests made by someone other than Member or the Member's prescriber:

Attach documentation showing the authority to represent the Member (a completed Authorization of Representation Form CMS-1696 or a written equivalent). For more information on appointing a representative, contact your plan.

***REQUIRED FIELDS – ONE MEDICATION PER FORM.**

*Member Name:	
*Member ID #:	*Date of Birth:
*Member Phone:	*Duration (how long therapy lasts): **Indefinite? ☐ YES ☐ NO** *If the box above is left blank, it will be assumed that the request is indefinite.*

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*Drug Name/Strength/Form (i.e., tablet, capsule):	*Quantity:
	*Frequency (i.e., how often, how many):
*__Generic Substitution Permitted:__ ☐ **YES** ☐ **NO** *If this field is left blank, it is assumed that the request is for what the pharmacy is processing (if applicable). If there is no pharmacy claims history, it is assumed that the request is the specific form of the drug listed in the *Drug Name field.*	
*Associated Diagnosis: *list all diagnoses and ICD-10 codes being treated with the drug.*	
*Submitting Provider NPI:	*Provider Name (First Name & Last Name):
*Provider Mailing Address (including city, state, ZIP):	
Provider Phone:	Provider Fax:
*Office Contact Name:	*Provider Signature:
Pharmacy Name:	Pharmacy Phone:
*Drug Allergies:	
DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)	
Drugs Tried: if quantity limit is an issue, list unit dose/total daily dose tried	**RESULTS of previous drug trials. Indicate FAILURE vs INTOLERANCE** (explain)
What is the Member's current drug regimen for the condition(s) requiring the requested drug?	

Type of Coverage Request (Please check boxes that describe restrictions for the drug you are asking for. If we ask for more information, you may include it below or on a separate page.):

❑ **Prior Authorization/Step Therapy – I need a drug with a requirement.** Please let us know how you have satisfied the requirements.

❑ **Non-Formulary Exception – I need a drug that is not on the plan's list of covered drugs.** Tell us about all the drugs you have tried that are on our list of covered drugs (sometimes called a "formulary"), but have not been effective for your treatment.

❑ **Quantity Limit Formulary Exception – I need a drug with a dosage and/or duration limit.** If we limit the number of doses and/or the duration, tell us why you need more of the restricted drug.

Reasons for Your Request. Use the space below and attach additional pages, if needed. **A supporting statement from your doctor is required.** Attach any information that supports your request, such as a statement from your doctor and relevant medical records.

'Ohana Health Plan complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently because of race, color, national origin, age, disability or sex.

'Ohana Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

'Ohana Health Plan provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **1-888-846-4262** (TTY **711**).

If you believe that 'Ohana Health Plan has failed to provide these services or discriminated in another way, you can file a grievance with:

'Ohana Health Plan
Attn: Grievance Department
949 Kamokila Boulevard
Suite 350
Kapolei, HI 96707
Toll-free: **1-888-846-4262**
TDD/TTY: **711**
Fax: **1-813-865-6861**

You can file a grievance in person or by mail or fax. If you need help filing a grievance we are available to help you. Call Customer Service toll-free at **1-888-846-4262** (TTY: **711**).

You can also file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, **800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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(English) Do you need help in another language? We will get you a free interpreter. Call **1-888-846-4262** (TTY: **711**).

(Cantonese) 您需要其它語言嗎？如有需要，請致電 **1-888-846-4262**，我們會提供免費翻譯服務 (TTY: **711**)。

(Chuukese) En mi niit alilis lon pwal eu kapas? Sipwe angei emon chon chiaku ngonuk ese kamo. Kori **1-888-846-4262** (TTY: **711**).

(French) Avez-vous besoin d'aide dans une autre langue? Nous pouvons vous fournir gratuitement des services d'un interprète. Appelez le **1-888-846-4262** (TTY: **711**).

(German) Brauchen Sie Hilfe in einer andereren Sprache? Wir koennen Ihnen gern einen kostenlosen Dolmetscher besorgen. Bitte rufen Sie uns an unter **1-888-846-4262** (TTY: **711**).

(Hawaiian) Makemake `oe i kokua i pili kekahi `olelo o na `aina `e? Makemake la maua i ki`i `oe mea unuhi manuahi. E kelepona iā **1-888-846-4262** `oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: **711**).

(Ilocano) Masapulyo kadi ti tulong iti sabali a pagsasao? Ikkandakayo iti libre nga paraipatarus. Awagan ti **1-888-846-4262** (TTY: **711**).

(Japanese) 貴方は、他の言語に、助けを必要としていますか？私たちは、貴方のために、無料で 通訳を用意で きます。**1-888-846-4262** (TTY: **711**) まで、お電話にてご連絡ください。

(Korean) 다른언어로 도움이 필요하십니까? 저희가 무료로 통역을 제공니다. **1-888-846-4262** (TTY: **711**) 번으로 전화해 주십시오.

(Mandarin) 您需要其它语言吗？ 如有需要，请致电 **1-888-846-4262**，我们会提供免费翻译服务 (TTY: **711**)。

(Marshallese) Kwoj aikuij ke jiban kin juon bar kajin? Kim naj lewaj juon am dri ukok eo ejjelok wonen. Kaaļọk **1-888-846-4262** (TTY: **711**).

(Samoan) E te mana'o mia se fesosoani i se isi gagana? Matou te fesosoani e ave atu fua se faaliliu upu mo oe. Telefoni mai: **1-888-846-4262** (TTY: **711**).

(Spanish) ¿Necesita ayuda en otro idioma? Nosotros le ayudaremos a conseguir un intérprete gratuito. Llame al **1-888-846-4262** (TTY: **711**).

(Tagalog) Kailangan ba ninyo ng tulong sa ibang lengguwahe? Ikukuha namin kayo ng libreng tagasalin. Tumawag sa **1-888-846-4262** (TTY: **711**).

(Tongan) 'Oku ke fiema'u tokoni 'iha lea makehe? Te mau malava 'o 'oatu ha fakatonulea ta'etotongi. Telefoni mai **1-888-846-4262** (TTY: **711**).

(Vietnamese) Bạn có cần giúp đỡ bằng ngôn ngữ khác không ? Chúng tôi se yêu cầu một người thông dịch viên miễn phí cho bạn. Gọi số **1-888-846-4262** (TTY: **711**).

(Visayan) Gakinahanglan ka ba ug tabang sa imong pinulongan? Amo kang mahatagan ug libre nga maghuhubad. Tawag sa **1-888-846-4262** (TTY: **711**).