'OHANA HEALTH PLAN – INJECTABLE INFUSION FORM

Prior Authorization Request for 'Ohana Health Plan
FAX to **1-888-877-8239** Injectable Infusion Department
Requested by: ☐ Physician ☐ Member

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

Please Check One (Not checking a box will indicate a Standard Review.)

☐ **REQUEST FOR STANDARD REVIEW (14 DAYS)**

☐ **REQUEST FOR EXPEDITED REVIEW (3 BUSINESS DAYS)**

By checking the Expedited Review box, the requestor certifies that applying the Standard Review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Complete each section legibly and completely (include any additional necessary medical records or laboratory results).		Date of Request:	
Member ID #:		Provider ID #:	
Member Name:		Physician NPI:	
Member's Date of Birth:		Physician Name:	
Member Phone:		Contact Name at MD Office:	
Diagnosis of Requested Medication**:**		Physician Phone:	
Height:	Weight (lb/kg):	Physician Fax:	
Allergies:		Pharmacy Phone:	Pharmacy Fax:

Requested Medication Name	**Dose**	**Frequency**	**Length of Treatment**

(*Please use another form if more lines are needed.)*

Physician Signature:

Document clinical rationale for request. List all names and doses of previous medication(s) tried and failed. Include all supporting documentation.

'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona, Inc.
Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

1. Is the medication being supplied and administered in physician's office? ☐ Yes ☐ No
2. 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 from the patient.
3. Is the medication being administered at a facility or outpatient center? ☐ Yes ☐ No
   Facility Name/Outpatient Clinic**:** _____
   Facility Name/Outpatient Clinic Provider ID #:_____

Is the medication being administered at the patient's home? ☐ Yes ☐ No