

Cough & Cold Products - Hawaii Prior Authorization Request Form

Please complete this <u>entire</u> form and fax it to: 866-940-7328. If you have questions, please call 800-310-6826. This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

First Name: Last Name: City: State: ZIP code:	Section A – Member Infor	mation								
City: State: ZIP Code: Allergies: Phone: DOB: Allergies: Allergies: Primary Insurance Information (if any): Is the requested medication: New or Continuation of Therapy? If continuation, list start date: Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: Is this member: Is this member Is the patient Is the	First Name:		Last Name	:		Membe	er ID:			
Primary Insurance Information (if any): Is the requested medication: New or Continuation of Therapy? If continuation, list start date:	Address:									
Primary Insurance Information (if any): Is the requested medication: New or Continuation of Therapy? If continuation, list start date:	City:		State:	State:				ZIP Code:		
Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: □ Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: □ Section B - Provider Information Section B - Provider Information	Phone:		DOB:			Allergies:				
Is this patient currently hospitalized?	Primary Insurance Information	(if any):								
Section B - Provider Information First Name: Last Name: City: State: ZiP code: Phone: Phone: Fax: NPI #: Specialty: Office Contact Name / Fax attention to: Section C - Medical Information Medication: Directions for use: Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant? Yes No If yes, what is this member's due date? Section D - Previous Medication Trials Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation Section E - Additional information and Explanation of why preferred medications would not meet the patient's needs:	Is the requested medicati	ion: 🗆 New or 🗆	Continuat	ion of Ther	apy? If continuation,	ist sta	rt date:	_		
First Name: Last Name: M.D./D.O.	Is this patient currently h	ospitalized?	Yes □ No	If recently	discharged, list discl	harge o	date:			
Address: City: State: ZIP code:		mation								
Phone: Fax: NPI #: Specialty: Office Contact Name / Fax attention to: Section C - Medical Information Medication: Strength: Directions for use: Quantity: Diagnosis (Please be specific & provide as much information as possible): ICD-10 CODE: Is this member pregnant?						T =				
Office Contact Name / Fax attention to: Section C - Medical Information Medication: Directions for use: Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant? Yes No				_				ZIP code:		
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Medication: Directions for use: Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant?	Office Contact Name / Fax atte	ention to:								
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Diagnosis (Please be specific & provide as much information as possible): Is this member pregnant? □ Yes □ No	Medication:						Strength:			
Is this member pregnant?	Directions for use:						Quantity:			
Section D – Previous Medication Trials Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:	Diagnosis (Please be specific	& provide as muc	h information	as possible)	:		ICD-10 CC	DDE:		
Medication Name Strength Directions Dates of Therapy Reason for failure / discontinuation Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:	_		If yes,	what is this	member's due date?					
Medication Name Strength Directions Dates of Therapy discontinuation Dates of Therapy discontinuation		ication Trials					Peasor	a for failure /		
	Medication Name	Strength	Dire	ctions	Dates of Therapy	y				
	Section E – Additional info	ormation and Ex	(planation	of why pref	erred medications wo	uld no	t meet the	e patient's needs:		



Provider Signature: _____

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Member First	name:	Member Last name:	Member DOB:				
Clinical and Drug Specific Information							
ALL REQUESTS							
□ Yes □ No	Does the patient have a history of failure, contraindication, or intolerance to any preferred cough and cold products? (If yes, complete Section D above)						
PATIENTS LESS THAN 18 YEARS OF AGE							
□ Yes □ No	Does the prescriber attest they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary? If yes, document rationale for use:						
□ Yes □ No		comorbid condition that may impact resse, sleep apnea, body mass index greation:					
□ Yes □ No	Has the patient tried and (If yes, complete Section I	failed any non-opioid containing cougl	h and cold remedy?				
QUANTITY LIMIT & EXCEEDING 90 MME CUMULATIVE THRESHOLD							
□ Yes □ No	Does the prescriber atte	st that a larger quantity is medically ned	cessary?				
□ Yes □ No		st they are aware of patient's current op nd feels the treatment with the requeste					

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