

## PRIOR AUTHORIZATION REQUEST FORM

For additional copies of this form, go to [www.mdxhawaii.com](http://www.mdxhawaii.com).

HEALTH SOLUTIONS®  
FAX to: (808)-532-6999

Today's Date: \_\_\_\_\_

PLEASE PRINT LEGIBLY.

### SECTION 1: REQUESTING PROVIDER

Provider's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address/Location (required): \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Note: If this is an HMO member, you must be approved to see this member before requesting services.**

Check "✓" this box if you would like to request a peer-to-peer conversation with an MDX Hawaii Physician Reviewer before a determination is made. We will contact you to arrange a date and time for your dialogue with our Medical Reviewer. Or, call us at (808) 426-7617 to schedule and provide best contact date(s)/time(s) and phone number of the Provider.

Routine  Urgent MD signature  \_\_\_\_\_ (Urgent requests require MD signature)

### SECTION 2: PATIENT

Check one:  UnitedHealthcare  Humana

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Sex:  Male  Female

Home Address: \_\_\_\_\_

Best Contact Phone # (required): \_\_\_\_\_

City, State & Zipcode: \_\_\_\_\_

### SECTION 3: REFERRED TO PROVIDER

Provider's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address/Location (required): \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### SECTION 4: SERVICE LOCATION

Service Location:  Home  Office  Outpatient Hospital  Ambulatory Surgery  Inpatient-ELOS: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### SECTION 5: MEDICAL/TREATMENT

Date of Service (DOS): From: \_\_\_\_\_ To: \_\_\_\_\_  DOS Pending Authorization

Please attach clinical notes/documentation of medical necessity for requested services.

ICD-10 Diagnosis Code(s)	Diagnoses
Procedure Code(s)	Procedures / Treatments
Durable Medical Equipment (DME): <input type="checkbox"/> Rental <input type="checkbox"/> Purchase (Attach MD order, medical documents, NCD and cost)	
PT/OT/ST: All requests for PT/OT/ST must include signed orders from the requesting provider. Ongoing services may not be submitted as "urgent".	
<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuing: Number of visits & frequency: _____ How many visits did the patient already have? _____ Last DOS: _____ For PT/OT/ST, include the evaluation and progress notes.

Once approved by MDX Hawaii's Medical Management Department, this authorization is valid for the listed number of authorized visit(s)/date(s), the condition as indicated, and only for the patient identified. NOTE: Coverage is dependent on member's eligibility and plan evidence of coverage at the time of service. All services are subject to medical necessity review.

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**SECTION 6: DRUGS AND MEDICATION**

**This section is for Medicare Part B medications that require prior approval when delivered in the physician's office, clinic, outpatient or home setting through home health or infusion companies. For the most current listing of medications that require prior authorization, please refer to the PA Look-Up Tool, Medications Tab on our website at [www.mdxhawaii.com](http://www.mdxhawaii.com).**

**Patient Name:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_

**Attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.**

J-CODE and NDC	Drug Name	Dose	Directions for use/SIG
J-Code			
NDC			
J-Code			
NDC			
J-Code			
NDC			
J-Code			
NDC			
J-Code			
NDC			

Is the medication being requested for use in an ongoing investigational trial?  
 NO  YES If yes, Trial name: \_\_\_\_\_ Registration number \_\_\_\_\_

Is the request for a reauthorization?  
 NO  YES **If yes, how many treatments have been completed?** \_\_\_\_\_

Is the patient currently stable on therapy?  
 YES  NO

Provide the start date and **expected length of treatment**.

List all therapeutic alternatives previously used with start/end dates and outcomes:

Additional comments that would be of benefit to the review of this request:

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that MDX Hawaii'i or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

 \_\_\_\_\_  \_\_\_\_\_  
**Prescriber Signature** **Date**

AN AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.  
 COVERAGE IS DEPENDENT ON THE MEMBER'S ELIGIBILITY AND PLAN EVIDENCE OF COVERAGE AT THE TIME OF SERVICE.  
 All services are subject to medical necessity review.