

**MEDICATION PRIOR AUTHORIZATION REQUEST FORM**  
for members under Hawaii-Western Management Group, Inc. (HWMG)

Fax completed form to **888.610.1180** or email to **PASupport@RxBenefits.com**  
Electronic version available at **https://rxb.promptpa.com**

**Incomplete form will delay the coverage determination. Please fill out all sections completely and legibly.**  
**Documentation is required for all requests.**

<b>Request Date:</b>				<input type="checkbox"/> Request to expedite review
<i>If the prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request, please mark above the request to expedite this review process.</i>				
<b>Patient Information</b>				
<b>This section must be filled out completely to ensure HIPAA compliance</b>				
First Name:		Last Name:		Phone Number:
Address:			City:	State:      Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female		Height (in/cm): _____ Weight (lb/kg): _____ (Include If Applicable)	
<b>Prescriber Information</b>				
First Name:		Last Name:		Specialty:
Address:			City:	State:      Zip Code:
NPI Number (individual):			Phone Number:	
Fax Number (in HIPAA compliant area):				
<b>Dispensing Pharmacy Information</b>				
Pharmacy Name:			Pharmacy Fax Number (in HIPAA compliant area):	
<b>Medication and Medical Information</b>				
Medication Name and Strength:			<input type="checkbox"/> Dispense as written <input type="checkbox"/> Generic substitution permitted* <i>*default is generic substitution permitted</i>	
Directions for Use:			Quantity and day supply:	
Start Date:	End Date:	Total number of doses:		<input type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit
<input type="checkbox"/> New Therapy	<input type="checkbox"/> Continuation of Therapy - Start Date: _____			For multiple medication requests, please provide all details of each agent in a separate list
If the patient has tried other medication(s) for this condition, please provide a list of previously tried and failed agents, including dates and reason(s) for failure				
Reason for use of medication:			ICD 10 codes(s) and diagnosis:	
<b>Has documentation (i.e., chart notes, pertinent lab values, medical history, etc.) been provided?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
Prescriber attests that the provided information is complete and accurate and understands that RxBenefits, Inc. reserves the right to perform an audit requesting the medical information necessary to verify accuracy at any time.				
Prescriber Signature: _____				Date: _____
<b>Confidentiality Notice:</b> The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.				