FORM INSTRUCTIONS
DHS 1144B (Rev. 03/07)
Request for Medical Authorization of Home Infusion or Medication Prior Authorization (PA)

PURPOSE:
Fee For Service program request for medical authorization of home infusion or medication PA.

FORM INSTRUCTIONS:
1. **Medicaid ID Number:** Enter the Medicaid I.D.
2. **Recipient's Name:** Enter the recipient's name (Last, First, MI).
3. **Gender:** Check the recipient's gender.
4. **Date of Birth:** Enter the recipient's date of birth: mm/dd/yyyy.
5. **Medicare Coverage:** Check whether the recipient has Medicare coverage and is receiving Medicare Home Health Benefits.
6. **Currently At:** Check where the recipient is currently located and enter the mailing address.
7. **Expanded Early & Periodic Screening Diagnosis & Treatment (EPSDT):** Check whether the recipient has received expanded early and periodic screening diagnosis & treatment.
8. **NDC Number or Drug Name, Strength, Units, or Global Code, or HCPCS:** Enter the NDC Number and units or Drug Name with strength and units, or Global Code and units, or HCPCS Code and units.
9. **QTY:** Enter the quantity.
10. **Purchase Price:** Enter the purchase price.
11. **Rent/Repair:** Circle whether this request is for rent or repair and enter the amount.
12. **Period Requested:** Enter the Period Requested From: and To:.
13. **Diagnosis or ICD-9 code:** Enter the diagnosis code or the ICD-9 code.
14. **BMI (for anorexiants):** Enter the BMI.
15. **Period Requested:** Enter the period requested.
16. **Prognosis:** Enter the prognosis.
17. **Justification:** Enter the justification and include any history of previous treatment. Check if any attachments are included.
18. **Print Prescriber's Name / Mailing Address:** Print the prescriber's name and mailing address.
19. **Prescriber's Signature:** Prescriber's: Sign the form.
20. **Prescriber's NPI:** Enter the prescriber's National Provider Identifier (NPI).
21. **Date:** Enter the date of signature.
22. **Telephone #:** Enter the prescriber's telephone number.
23. **Fax #:** Enter the prescriber's fax number.
24. **Contact Name:** Enter the name of the person to contact.
25. **Print Supplier's Name / Mailing Address:** Print the supplier's name and mailing address.
26. **Comments:** Enter any comments.
27. **Contact Name:** Enter the name of the person to contact at the supplier.
28. **Telephone #:** Enter the supplier's telephone number.
29. **Fax#:** Enter the supplier's fax number.
30. **Supplier's Signature:** Sign the request.
31. **Supplier's NPI:** Enter the supplier's or pharmacy's NPI.
32. **Date:** Enter the date of signature.

FILING INSTRUCTIONS:
1. Retain the original hard copy and submit by fax to ACS at 1(888)335-8474;

OR

2. Retain a copy and submit by mail the original hard copy to:

   ACS
   Hawaii State Medicaid Fee for Service Program
   Attn: DUR
   P.O. Box 967
   Henderson, NC 27536-0967