Hawaii State Health Planning and Development Agency
1177 Alakea St. #402 Honolulu, Hawaii 96813
Phone: 808-587-0788 Fax: 808-587-0783 Web: https://health.hawaii.gov/shpda

Healthcare Prior Authorization Report

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Instructions

If your health plan covers the service(s) highlighted in YELLOW below (03, 04, 07, 08, 09, 13, 15), please complete the form(s) relevant to the service(s):

Services	Form #
~~01=At Risk Services~~	~~Form-1~~
~~02=Autism Services~~	~~Form-2~~
03=Diagnostic Testing	**Form-3**
04=Durable Medical Supplies/Medical Equipment	**Form-4**
~~05=Home and Community Based Services~~	~~Form-5~~
~~06=Home Health Services~~	~~Form-6~~
07=Inpatient Hospital Services	**Form-7**
08=Outpatient Hospital Services	**Form-8**
09=Physician Services	**Form-9**
~~10=Preventive Services~~	~~Form-10~~
~~11=Rehabilitation Services~~	~~Form-11~~
~~12=Transportation Services~~	~~Form-12~~
13=Behavioral Health	**Form-13**
~~14=Other Services~~	~~Form-14~~
15=Drugs	**Form-15**

Additional copies of instructions and report forms are available at:

https://health.hawaii.gov/shpda/agency-resources-and-publications/prior-authorization-reporting/

Three (3) ways to return the report form(s) to SHPDA:	Questions?
1) Email to: dailin.ye@doh.hawaii.gov, or	Email: dailin.ye@doh.hawaii.gov
2) Fax to: 808-587-0783, or	Phone: 808-587-0852
3) Mail to: SHPDA Prior Authorization Report Hawaii State Health Planning and Development Agency 1177 Alakea St. #402, Honolulu, HI 96813	

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Form-#: Sample

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:	ABC Health Plan	Report date:	1/6/2026
Name of Insurer:	XYZ Health Insurance Company		
Address of Insurer:	1234 Street Name, City, Zip Code		
Leadership of Insurer:	Name/Title (e.g. President, CEO, CFO, etc.)	Phone:	(808)-123-4567 (Point of Contact)
Completed by: (name)	Name	Fax:	(808)-100-2000
(title)	Title	Email:	Email (Point of Contact)

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests	50000	40000	10000	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)	35000	29500	5500	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)	10000	7500	2500	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal	5000	3000	2000	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approved (B)	Denied (C)	Withdrawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests	50000	40000	10000	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)	35000	29500	5500	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)	10000	7500	2500	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal	5000	3000	2000	0	01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	Enter
						04=Prior authorization timelines not met*	Actual
						05=Out-of-network providers	Counts
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days	5	4	Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours	1	1	Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests.

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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Form-3: Diagnostic Testing

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Leadership of Insurer:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days			Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours			Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests.

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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Form-4: Durable Medical Supplies/Medical Equipment

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Leadership of Insurer:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days			Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours			Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests**.**

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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Form-7: Inpatient Hospital Services

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Leadership of Insurer:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days			Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours			Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests**.**

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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Phone: 808-587-0788 Fax: 808-587-0783 Web: https://health.hawaii.gov/shpda

Form-8: Outpatient Hospital Services

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Leadership of Insurer:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days			Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours			Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests**.**

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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Form-9: Physician Services

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Leadership of Insurer:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days			Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours			Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests**.**

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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Form-13: Behavioral Health

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Leadership of Insurer:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days			Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours			Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests**.**

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.

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Phone: 808-587-0788 Fax: 808-587-0783 Web: https://health.hawaii.gov/shpda

Form-15: Drugs

Reporting Periord: January 1 to December 31, 2024

(Please Complete One Set of Report for Each Specific Health Plan. Due Date: January 31, 2026)

Name of Health Plan:		Report date:	
Name of Insurer:			
Address of Insurer:			
Leadership of Insurer:		Phone:	
Completed by: (name)		Fax:	
(title)		Email:	

Section I. Standard (Non-Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
1.	Standard PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
2.	Standard PA Decision Made within 7 Days (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
3.	Standard PA Decision Made with Extension (up to 14 days) (Report Standard PA Appeals in Line 4)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
4.	Standard PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section II. Expedited (Urgent) Prior Authorization (PA) Requests

		Total (A)	Approv-ed (B)	Denied (C)	With-drawn (D)	Among the total number of denials reported in column C, how many denials were due to one of the following reasons? Count one primary reason for each denial and enter the count for each reason in column F. (E) (*See note)	Counts of Reasons (F)
5.	Expedited PA Requests					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
6.	Expedited PA Decision Made within 72 Hours (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
7.	Expedited PA Decision Made with Extension (up to 14 days) (Report Expedited PA Appeals in Line 8)					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	
8.	Expedited PA Decision Made after Appeal					01=Incomplete or Incorrect Information*	
						02=Medical necessity criteria not met	
						03=Non-covered services or exceeding limits	
						04=Prior authorization timelines not met*	
						05=Out-of-network providers	
						06=Lack of step therapy/testing attempts	
						07=Therapy requires multiple PA requests*	
						08=Non-formulary medications	
						09=Other* **Specify. Add row as needed.**	

Section III. Time Between Payer Receiving a Prior Authorization Request and Sending a Decision

		Mean (Average) Time	Median (Middle) Time	
9.	Standard PA Decision Made within 7 Calendar Days			Day(s)
10.	Standard PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
11.	Standard PA Decision Made after Appeal	Optional	Optional	Day(s)
12.	Expedited PA Decision Made within 72 Hours			Day(s)
13.	Expedited PA Decision Made with Extension (up to 14 Days)	Optional	Optional	Day(s)
14.	Expedited PA Decision Made after Appeal	Optional	Optional	Day(s)

Notes:

Column E: 01=Incomplete or Incorrect Information*

This might include any of the following: missing or incorrect patient information; errors in ICD-10 or CPT/HCPCS codes; missing medical records, inadequate physician notes, lack of relevant lab results, or failure to include previous treatment histories; etc.

Column E: 04=Prior authorization timelines not met*

This might also include expired authorization or duplicate requests**.**

Column E: 07=Therapy requires multiple PA requests*

Some treatments require separate prior authorization requests for pharmacy and medical benefits.

Column E: 09=Other*

This might include but is not limited to any of the following: Invalid preauthorization request form submitted; Pre-existing condition exclusion; Lack of peer-to-peer review; Treatment is not consistent with published clinical evidence; Experimental; Prescribing physician's qualification; etc. Please specify reason of denial. Add row as needed.