PHARMACY DRUG/PRODUCT PRIOR AUTHORIZATION FORM

Instructions: Fill out all applicable sections completely and legibly. ***Indicates Required Field**
Attach any additional documentation that is important for the review, e.g., chart notes or lab data, to support the request.

*DATE OF REQUEST: / /	*PRIORITY: ☐ Standard (Non-Urgent) ☐ Urgent (defined as significant impact to member's health)

MEMBER INFORMATION

*Last Name, First Name:	*Date of Birth: / /	*Molina ID:	☐ Male ☐ Female
*Diagnosis ICD-10 Code:	*Diagnosis Description:	Allergies:	
Address:		State:	Zip Code:
Request Type: ☐ Initial/New Start ☐ Re-Authorization/Continuity (Established on Date: / /) ☐ Established in Hospital (Established on Date: / /)			

REQUESTING PROVIDER INFORMATION "Refer From Provider" (Complete for ALL Requests)

*Last Name, First Name:	*NPI:	*Phone: ( )	*Fax: ( )
Address:		State:	Zip Code:

ADMINISTERING PROVIDER INFORMATION "Refer To Provider/Facility" (Only Complete for Medical Benefit: Not Dispensed by Pharmacy)

*Last Name, First Name or Facility:	*NPI:	*Phone: ( )	*Fax: ( )
Address:		State:	Zip Code:

REQUESTED PRESCRIPTION DRUG/PHARMACY PRODUCT (Only Complete for Pharmacy Prescription Drug Benefit)

Name:	Dose/Strength:	Quantity:	Day Supply:	# Refills:
Directions (SIG):	Administration: ☐ Oral/SL ☐ Topical ☐ Injection ☐ Other: _____			

REQUESTED OUTPATIENT DRUG/PHARMACY PRODUCT (Only Complete for Medical Benefit: Not Dispensed by Pharmacy)

	HCPC/CPT Code	Description	#Units/Vists	Start Date	End Date
1				/ /	/ /
2				/ /	/ /
3				/ /	/ /
4				/ /	/ /
5				/ /	/ /

RELATED DRUG/PHARMACY PRODUCT HISTORY

	Name	Dose/Strength	Directions (SIG)	Dates of Therapy	Rationale for Failure
1				/ / - / /	
2				/ / - / /	
3				/ / - / /	
4				/ / - / /	
5				/ / - / /	

CLINICAL INFORMATION

Medical Justification for Request:

PROVIDER CERTIFICATION

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Molina Healthcare.

Prescriber/Authorized Representative Signature:_____ Date: ____/____/____

Please fax your completed request to the appropriate fax# shown below for the member's state.

AZ	CA	FL	IA	ID	IL	KY	MI	MS	NE
844-271-6887	866-508-6445	866-236-8531	877-733-3195	844-312-6407	855-365-8112	844-802-1406	888-373-3059	844-312-6371	877-281-5364
NM	**NV**	**NY**	**OH**	**SC**	**TX**	**UT**	**VA**	**WA**	**WI**
866-472-4578	844-259-1689	844-823-5479	800-961-5160 (Rx) 866-449-6843 (JCode)	855-571-3011	888-487-9251	866-497-7448	844-278-5731	800-869-7791 (Rx) 800-767-7188 (JCode)	844-802-1417 (Rx) 877-708-2117 (JCode)