



# 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)<br>866-449-6843 (JCode) | 855-571-3011 | 888-487-9251 | 866-497-7448 | 844-278-5731 | 800-869-7791 (Rx)<br>800-767-7188 (JCode) | 844-802-1417 (Rx)<br>877-708-2117 (JCode) |

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