Molina Healthcare of Washington
Prior Authorization/Medication Exception Request Form

Phone Number: (800) 213-5525
Fax Number: (800) 869-7791

Please provide the information below, print your answers, attach supporting documentation, sign, date and return to our office as soon as possible to expedite this request.

_____ **Urgent** _____ **Reauthorization**				
PATIENT INFORMATION				
First Name:	MI:	Last Name:	DOB:	Molina Member ID#:
PHYSICIAN INFORMATION				
First Name:	MI:	Last Name:	Prescriber Phone:	Prescriber Fax:
Physician NPI:			Specialty:	
Medication Information (This information is required for processing) *Generic substitution is required when available				
Drug Name, Strength and Directions:				
Pharmacy Name:		Pharmacy NPI:	Pharmacy Phone:	Pharmacy Fax:
Diagnosis/Medical Justification:				
Previous Medications Tried and Dates of Use:				
Comments:				
Physician Signature (I certify that all of the information on this form is true and accurate to the best of my knowledge) **X**				Date:

Approvals are subject to the member's co-pays and deductibles for their plan and all authorized prescriptions must be filled at participating pharmacies unless specifically authorized at an out of network facility. The Molina Healthcare Formulary is available on our website MolinaHealthcare.com.