MOLINA HEALTHCARE

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Prior Authorization (PA) Form
PRESCRIPTION DRUG

If the following information is not complete, correct, or legible, the PA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Molina Healthcare ID Number:

Date of Birth: ___ – ___ – ____

Member's Phone Number: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

NPI Number:

Specialty: _____

Prescriber's Phone Number: ___ – ___ – ____

Prescriber's Fax Number: ___ – ___ – ____

Street Address:

City:

State:

Zip Code:

DRUG INFORMATION

Drug Name: _____

Strength: _____

Directions for Use: _____

Diagnosis: _____

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DRUG INFORMATION *(Continued)*

Date member started medication *(if previously started)*: _____

Name of specific medication(s) tried and failed *(Samples do not qualify as a trial and failure of medication)*:

_____

_____

Reason for non-formulary request, and/or clinical justification for requested drug use (Please include relevant lab values when appropriate. **Note:** Member chart notes will be requested if further documentation is necessary): _____

_____

_____

Additional notes: _____

_____

_____

_____

Please include ALL requested information; Incomplete forms will delay the PA process. Submission of documentation does NOT guarantee coverage by Molina Healthcare. If you have any questions, please call **(800) 424-5891**. The completed form may be faxed to **(844) 271-6887**.