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)

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.