CVS CAREMARK
Customer Service
1-800-237-2767

INJECTABLE DRUG REQUEST FORM

FAX TO: 1-800-869-7791
FOR PRIOR AUTHORIZATION
MOLINA PHARMACY SERVICE: 1-800-213-5525

Date Needed: _____ (MM / DD / YY)

MOLINA HEALTHCARE

PATIENT INFORMATION: **PRESCRIPTION**

Patient Name (First):	Last:	M:	DOB:	Sex: ☐ M ☐ F	SSN:
Patient Address: (include apt. #)	City:		State:	Zip:	
Daytime Phone:	Evening Phone:		Best time to contact patient: ☐ Morning ☐ Evening		
Emergency Contact name, #, relationship:	Is the patient Medicare primary? ☐ Y ☐ N		Primary Language:		

PRESCRIPTION INFORMATION: If attaching an Rx, please include the ICD-9 code and physician signature.

Drug:	Dose: _____ mg	Quantity:
Sig:	Stop Date:	Refill _____ months
ICD-9 Code:	Physician Signature: _____	☐ **Generic substitution permissible** ☐ **Dispense as written**

SHIPPING INFORMATION:

Ship to:
☐ Physician's Office
☐ Patient's Home **(NO** PO Boxes please**)**
☐ Other**:** _____

Height: _____ / Weight: _____
Allergies (including food): _____

Current Medication Profile: (include OTCs & herbals)

Drug	Dose	Directions

PHYSICIAN INFORMATION: If physician's shipping or billing addresses are different, please attach on a separate sheet.

Physician Name:	Specialty:	
Physician Address (include all suite, bldg. #'s, etc.):		
Contact Name:	Phone # (include ext.):	Secure Fax #:
Physician UPIN #:	License #:	DEA #:

MOLINA HEALTHCARE USE ONLY:

☐ Pending	☐ APPROVED	Effective Date: _____
☐ More Information Required	Authorization Number:	Term Date: _____
☐ Denied	Comments:	
☐ Approved as Modified (See Comments)		

All refrigerated prescriptions are shipped standard overnight service. Orders are shipped for delivery by the "Date Needed" noted above. Saturday delivery requires approval from a pharmacist. Contact for refill coordination is made prior to the due date.