



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)

**PATIENT INFORMATION:****PRESCRIPTION**

Patient Name (First):	Last:	M:	DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SSN:
Patient Address: (include apt. #)			City:	State:	Zip:
Daytime Phone:		Evening Phone:		Best time to contact patient: <input type="checkbox"/> Morning <input type="checkbox"/> Evening	
Emergency Contact name, #, relationship:		Is the patient Medicare primary? <input type="checkbox"/> Y <input type="checkbox"/> 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: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home (NO PO Boxes please) <input type="checkbox"/> Other: _____ _____ _____ _____	Height: _____ / Weight: _____ Allergies (including food): _____ _____ Current Medication Profile: (include OTCs & herbals) <table border="1"> <thead> <tr> <th>Drug</th> <th>Dose</th> <th>Directions</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table>	Drug	Dose	Directions	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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:

<input type="checkbox"/> Pending	<input type="checkbox"/> APPROVED	Effective Date: _____
<input type="checkbox"/> More Information Required	Authorization Number: _____	Term Date: _____
<input type="checkbox"/> Denied	Comments: _____	
<input type="checkbox"/> 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.

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