



# Molina Healthcare Medication Prior Authorization Request Form

Allow 24 hours or 1 business day to process

Phone: (800) 526-8196 X127854 FAX: (866) 508-6445

## PATIENT INFORMATION:

Member Name (First, Last, MI):		Contact Phone Number:		
Molina Identification Number:	Date of Birth:	Gender:	Height:	Weight:

## PRESCRIBER INFORMATION:

Prescriber Name:		NPI number:		
		Specialty:		
Phone Number:		Fax Number:		

## PHARMACY INFORMATION:

Pharmacy Name:		Pharmacy NPI:		
Phone Number:		Fax Number:		

## MEDICATION REQUESTED: (LIMIT ONE MEDICATION REQUEST PER FORM)

\* The Molina Formulary is available to download onto your PDA at [www.ePocrates.com](http://www.ePocrates.com) or [www.Molinahealthcare.com](http://www.Molinahealthcare.com)

Drug name, strength, quantity, and dosing directions ( <b>GENERIC EQUIVALENT IS MANDATORY UNLESS OTHERWISE INDICATED</b> )		
Expected duration of use/# of refills:	Is this a NEW request or a RENEWAL?	If this is a Re-authorization, please indicate previous dates of use:
Where will drug be administered?	___NEW ___RENEWAL	

## MEDICAL JUSTIFICATION:

Diagnosis or ICD-9/ICD-10 codes:	Previous related medications tried with dates of use and reason of failure. (Include chart notes when possible).
Is this a Hospital or Urgent Care Discharge order? YES ___ NO ___	

## ADDITIONAL INFORMATION

➤ For **Cholesterol Lowering Agents** please attach Lipid panel drawn within the last 90 days.

Date:	Test:	Result:
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➤ For **Diabetes Agents** please attach Hemoglobin A1C Report drawn within the last 90 days

Date:	Test:	Result:
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➤ **Other Relevant Tests/Lab Results**

Date:	Test:	Result:
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## PRESCRIBER'S SIGNATURE: \_\_\_\_\_

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