



Drug Prior Authorization Form

Phone: (888) 669-4322

Fax: (888) 373-3059

Please make copies for future use.

Date of Request:			
**Pt. Name (Last):	**Pt's DOB:	**Pt's DOB:	**Pt's DOB:
**Pt. ID (Medicaid or MiChild ID):	Name of Person Completing form:		
Provider's Name	Provider's Specialty:		
Phone #: (Area Code) (Number)	Fax #: (Area Code) (Number)		

(*Information is required for review of request. Please print clearly.*)

- Patient being discharged from Hospital**
- Reauthorization Request**

Requests for certain medications will require additional information be provided. To expedite the authorization process, please include the following information when requesting these types of medication:

- Caremark Specialty Injectables/Non-Formulary Medications: Progress notes
- Cholesterol lowering (ie. Crestor, Vytorin, Zetia, Lovaza): Lipid Panel drawn within the last 90 days
- Diabetes (ie. Actos, Januvia): A1c Report drawn within the last 90 days
- Proton Pump Inhibitor (BID dosing only): Endoscopy Report
- Pain Management: Medication Log, Progress Notes

• Drug Requested: (Name, strength, dose, sig, quantity) **MAX 1 DRUG PER FORM**

• Estimated length of need:

• Diagnosis/medical indications for RX:

• Previous medications prescribed and outcome:

Prior Authorization form and Formulary booklet may be found at www.MolinaHealthcare.com