Molina Healthcare of New Mexico
Medication Prior Authorization Request Form

Fax: 866-472-4578
Phone: (800) 580-2811

To ensure a timely response, please fill out form completely and legibly. Decisions are made within 48 hours of receipt of all necessary information unless otherwise indicated as "Urgent" on this form.

Date of Request:

MEMBER INFORMATION

Last Name:	First Name:	Date of Birth:
ID Number:		

PROVIDER INFORMATION

Name:	Specialty:
Phone Number:	Fax Number:

- **Medication Requested:** (Include name, strength, directions and quantity)

- **Estimated duration of therapy:**

- **Diagnosis/medical indications for Rx:** (Send all pertinent clinical documentation with this fax. Use of pharmaceutical samples cannot be accepted as justification.)

- **Previous formulary medication trials:** (Length of treatment/outcome with dates)

☐ **Reauthorization of current medication** (recent clinical documentation required)

For Molina Use Only

☐ Approved ☐ Pending ☐ Denied

Duration _____

Reviewer Comments: