Molina Healthcare of Utah
Medication Prior Auth / Exceptions Request Form
Fax: (866) 497-7448
Phone: (855) 322-4081

***To ensure a timely response, please fill out form completely and legibly. **Chart note documentation is required.** Requests may be denied if chart note documentation is not included. ***

Date of Request

MEMBER INFORMATION

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

PROVIDER INFORMATION

Name & Specialty:	NPI #:
Phone Number:	Fax Number:

MEDICATION REQUESTED

Name of Medication:
Strength/Quantity:
Directions:
Estimated Duration of Therapy:

DIAGNOSIS/ MEDICAL INDICATION FOR RX (Send all pertinent clinical documentation with this fax.)

PREVIOUS MEDICATION TRIALS (Please include length of treatment and outcomes with dates. **Claim history or chart note documentation** showing trials of failed drugs is required. Use of pharmaceutical samples cannot be accepted as justification.)

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge.

Prescriber Print Name: _____ **Date:** _____

Prescriber Signature: _____