



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.)

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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.)

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

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

Prescriber Signature: _____

*****HIPAA Confidentiality Notice*****

CONFIDENTIALITY NOTICE: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.