



Molina Healthcare of Utah

Fax: (866)497-7448

Phone: (888) 483-0760

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:
Request type: <input type="checkbox"/> Initial request <input type="checkbox"/> Re-authorization <input type="checkbox"/> Urgent

❖ **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:	Dose/Directions:	Duration of therapy:
OR			
J Code:	J Units:	Dose/Directions:	Number of visits:

❖ **ICD 10 AND DIAGNOSIS**

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❖ **Previous Medication Trials** (Please include length of treatment, outcomes with dates. Claim history or chart note documentation showing trials of failed drugs is required. Use of drug 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: _____

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