Drug Prior Authorization Form

Phone: (855) 326-5059
Fax: (844) 802-1417

Date of Request:	Pt. DOB:
Pt. Name (Last):	(First):
Pt. ID:	Name of Person Completing form:
Provider's Name and Specialty	Provider's Address:
Phone #: (Area Code) (Number)	Fax #: (Area Code) (Number)

☐ **Hospital Discharge** ☐ **New Request** ☐ **Reauthorization**

Drug Requested: ***One drug request per form***

Name	Strength	Dose	Quantity

****OR****

J Code	ICD-10	Name of Treatment Facility	Tax ID of Treatment Facility	Number of Units

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:

☐ Specialty Injectables/Non-Formulary Medications: Progress notes

☐ Cholesterol Lowering: Recent Lipid Profile or ASCVD Risk Score

☐ Diabetes: A1c Report drawn within the last 90 days

☐ Pain Management: Medication Log, Progress Notes

- Estimated length of need:

- Diagnosis:

- Previous medications prescribed and outcome:

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