MOLINA HEALTHCARE | Molina Complete Care

**MOLINA COMPLETE CARE**
**Prior Authorization (PA) Form**
**PRESCRIPTION DRUG**

If the following information is not complete, correct, or legible, the PA process can be delayed.
Please use one form per member.

## MEMBER INFORMATION

**Member's Last Name:**

**Member's First Name:**

**MCC ID Number:**

**Date of Birth:** ___ – ___ – ____

**Member's Phone Number:** ___ – ___ – ____

**Gender:** ☐ **Male** ☐ **Female**

**Weight in Kilograms**: _____

## PRESCRIBER INFORMATION

**Prescriber's Last Name:**

**Prescriber's First Name:**

**NPI Number:**

**Specialty:** _____

**Prescriber's Phone Number:** ___ – ___ – ____

**Prescriber's Fax Number:** ___ – ___ – ____

**Street Address:**

**City:**

**State:**

**Zip Code:**

## DRUG INFORMATION

**Drug Name:** _____

**Strength:** _____

**Directions for Use:** _____

**Diagnosis:** _____

*(Form continued on next page.)*

**Member's Last Name:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

**Member's First Name:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

## DRUG INFORMATION *(Continued)*

**Date member started medication *(if previously started)***: _____

**Name of specific medication(s) tried and failed *(Samples do not qualify as a trial and failure of medication)***:

_____

_____

**Reason for non-formulary request, and/or clinical justification for requested drug use** (Please include relevant lab values when appropriate. **Note:** Member chart notes will be requested if further documentation is necessary): _____

_____

_____

**Additional notes**: _____

_____

_____

_____

**Please include ALL requested information; Incomplete forms will delay the PA process.** Submission of documentation does NOT guarantee coverage by Molina Complete Care. If you have any questions, please call **(800) 424-5891**. The completed form may be faxed to **(844) 271-6887**.