MOLINA HEALTHCARE
Your Extended Family.

Molina Healthcare of Illinois
Pharmacy Prior Authorization Request Form
For Pharmacy PA Requests, Fax: (855) 365-8112

Member Information

Member Name:	DOB:	Date:
Member ID #:	Sex:	Weight: Height:

Provider Information

Prescriber Name and Specialty:	NPI #:	Office Contact Name:
Prescriber Address:	Office Phone:	Office Fax:
Treatment Facility Name:	IL Medicaid Certified: ☐ Yes ☐ No	
Treatment Facility NPI:	Treatment Facility TIN:	

Medication Requested Molina Healthcare is a mandatory generic plan. ☐ New Request ☐ Reauthorization

Drug Name:	Strength:	Directions (Sig):
Qty: Refills:	ICD-10 & Diagnosis Name:	
☐ New Request ☐ Reauthorization		
Please complete the following section ONLY if Buy and Bill *(drug NOT dispensed via a Pharmacy)*		
HCPCS Code: Number of Units Requested: Date(s) of Service:		
Service Type: Choose one ☐ Elective/Routine: Determination **within 96 hours** from receipt of all necessary information. ☐ Expedited/Urgent I certify the request is urgent and medically necessary to treat an injury, illness or condition (not life-threatening) **within 48 hours** to avoid complications and unnecessary suffering or severe pain.		

Patient Previous Medication(s) Relevant to this Request (Complete for all requests)

Drug Name	Strength	Directions (Sig)	Duration Outcome & Reason for Discontinuation (Clinical Documentation Required)
1			
2			
3			
Use of drug samples will not be considered as rationale for approving a prior authorization request. Length of treatment/failure with dates must be supported in clinical documentation (chart notes).			

Required:

Medical Rationale for Request/Additional Clinical Information (Including diagnostic studies, lab results, & progress notes). Requests will not be processed if any of the information is missing: member information, provider information, and clinical documentation (chart notes). To ensure a timely response, please fill out the form completely and legibly.
ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge.
Provider Signature: Date:

*ALL REQUIRED FIELDS MUST BE COMPLETED. INCOMPLETE FORMS WILL BE REJECTED. Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures. Confidentiality: The information contained in the transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.