Molina Healthcare of Utah
Medicaid/CHIP
Fax: (866) 497-7448
Phone: (855) 322-4081

# Medical Benefit (HCPCS/J-Code) Drug Prior Authorization Request Form

*****This form is intended for OUTPATIENT requests and chart note documentation is required.**

***Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent**

| MEMBER INFORMATION | | | | | | |
|---|---|---|---|---|---|---|
| **Member Name:** | | | **Date of birth:** | / / | | |
| **Member ID#:** | | | **Phone:** | ( ) - | | |
| **Service Type:** | Elective/Routine | Expedited/Urgent* | NEW | REAUTH | **Date of Request:** | / / |

| PROVIDER INFORMATION | | | |
|---|---|---|---|
| **Requesting Provider Name and specialty:** | | **NPI#:** | **Office contact:** |
| **Provider Phone Number:** | ( ) - | **Provider Fax Number:** | ( ) - |
| **Servicing Provider or Facility:** | | **Facility NPI#:** | |
| **Facility Phone Number:** | ( ) - | **Facility Fax Number:** | ( ) - |

| DRUG/SERVICE REQUESTED | | | |
|---|---|---|---|
| **Diagnosis Code & Description:** | **Number of visits requested:** | **Dates of Service from: / / to / /** | |
| **J Code:** | **J Units:** | **Name of Medication:** | **Strength/Quantity:** |
| **Dosage & Frequency:** | **Duration of Therapy:** | **National Drug Code (NDC) and Unit of Measure:** | |

| PREVIOUS DRUG TRIALS |
|---|
| ** Please include trial dates and details of failure. These must be supported by claim history or chart note documentation. Use of drug samples cannot be accepted as justification** |

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

**Prescriber Signature:** **Date:**