

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:**

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Member's First Name:

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MOLINA ID Number:

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Date of Birth:

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Gender: ☐ Male ☐ Female**Weight in Kilograms:** _____**PRESCRIBER INFORMATION****Prescriber's Last Name:**

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Prescriber's First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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DRUG INFORMATION**Drug Name/Form:** _____**Strength:** _____**Dosing Frequency:** _____**Length of Therapy:** _____**Quantity per Day:** _____**DIAGNOSIS AND MEDICAL INFORMATION**

Antipsychotics in children younger than 18 years old—to receive approval for this drug, complete the following questions.

Indicate the diagnoses being treated (include ALL ICD codes, if applicable):

Member's Last Name:

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Member's First Name:

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List pharmaceutical agents attempted and outcome:

Prescriber signature (required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **FAXED to 1-844-278-5731**, or you may call (800) 424-4518 (TTY 711)