

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION**Member's Last Name:**

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MCC ID Number:

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Gender: ☐ Male ☐ Female**Member's First Name:**

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Date of Birth:

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Weight in Kilograms: _____**PRESCRIBER INFORMATION****Prescriber's Last Name:**

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NPI Number:

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Phone Number:

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Street Address:

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City:

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Prescriber's First Name:

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Specialty:

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Fax Number:

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State:

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Zip Code:

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DRUG INFORMATION**Drug Name:** _____**Strength:** _____**Directions for Use:** _____**Diagnosis:** _____

(Form continued on next page.)

Member's Last Name:

[illegible]

Member's First Name:

[illegible]

DRUG INFORMATION (Continued)

Date member started medication (if previously started): _____

Name of specific medication(s) tried and failed: _____

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: _____

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 Complete Care.

The completed form may be **FAXED TO 1-844-278-5731** or you may call the number below.

CCC Plus: 1-800-424-4524 (TTY 711)

Medallion 4.0: 1-800-424-4518 (TTY 711)