



SPECIALTY MEDICATION REQUEST FORM

Fax Prior Authorization request to (800) 869-7791

Molina Healthcare Pharmacy Services Phone: (844) 509-7581

Patient Information

First Name:	MI:	Last Name:	DOB:	Sex:	Member ID:
Street Address (include unit #):			City:	State:	Zipcode:
Daytime Phone:		Evening Phone:	Best Time to Contact:		
Emergency Contact Name, Relationship and Phone:					

Physician Information

Physician Name:	Specialty:	NPI or DEA:			
Street Address (include unit #):		City:	State:	Zipcode:	
Phone (include extension):			Secure Fax #:		

Medical Assessment

For new and re-authorization requests attach current notes and related clinical information

Diagnosis:

Prescription Information

Write prescription below or attach

Drug Name, Strength and Directions:

Number of Refills (duration):

Physician Signature (required for processing):
X

Date:

Shipment Information

Ship to (use address above)

Patient Home

Physician Office

Other Address (Physical Address only, no PO Boxes)

Street Address (include unit #):

City: State: Zipcode:

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