Drug Prior Authorization Form

Michigan Medicaid and Marketplace
Phone: (855) 322-4077
Fax: (888) 373-3059

Please make copies for future use.

Date of Request:	Patient DOB:
Patient Name (Last):	(First):
Patient ID (10 digit):	Name of Person Completing form:
Provider's Name:	Provider's Address:
Provider's NPI:	Provider's Specialty:
Phone #: (Area Code) (Number)	Fax #: (Area Code) (Number)

☐ **Hospital Discharge** ☐ **New Request** ☐ **Reauthorization**

Drug Requested: ***One drug request per form***

Name	Strength	Dose	Quantity

OR

HCPCS	ICD	Name of Treatment Facility	Tax ID of Treatment Facility	Number of Units

- Estimated length of need:
- Diagnosis:
- Previous medications trialed and outcome:

Prior Authorization form and Formulary booklet may be found at www.MolinaHealthcare.com

Revised 10_15_ddg