MOLINA HEALTHCARE
Your Extended Family

Healthy Connections

Non-Preferred Medication Exception Member Inquiry

Molina Healthcare of South Carolina, LLC

Instructions: Please complete all sections clearly. Include any additional documents that are important for this request.

Member (Patient) Information					
*First Name:	*Last Name:		Middle Initial:	*Phone Number:	
*Address:	*City:		*State:	*Zip Code:	
Email Address:					
*Date of Birth:	☐ Male ☐ Female	Height:	Weight:	Allergies:	
*Molina Member ID Number:					

Non Preferred Drug Information		
*Drug Name:	Strength / Dose:	Number of times taken per day:
Diagnosis:		

Physician (Prescriber) Information			
*First Name:	*Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
*Phone Number:	Fax Number:	Email Address:	

Molina Healthcare of South Carolina will research this request, and contact your doctor about this request, as appropriate. Molina or your doctor will contact you about the outcome of this request within 14 calendar days.

*Required information

Please mail completed form to:

Molina Healthcare of South Carolina, LLC
ATTN: Pharmacy Services Department
P.O. Box 40309
North Charleston, SC 29423-0309

If you have any questions or don't understand, please call Molina Healthcare of South Carolina Member Services at 1-855-882-3901 or for hearing impaired TTY/South Carolina Relay 1-800-735-2905 or 711 for help. We will explain by talking with you in English or in your native language.