Molina Healthcare of Utah
Fax: (866)497-7448
Phone: (888) 483-0760

To ensure a timely response, please fill out form completely and legibly. **Chart note documentation is required.** Requests may be denied if chart note documentation is not included.

Date of request:		
Request type: ☐ Initial request	☐ Re-authorization	☐ Urgent

❖ MEMBER INFORMATION

Last Name:	First Name:	Date of Birth
ID Number:		

❖ PROVIDER INFORMATION

Name & Specialty:	NPI #:
Phone Number:	Fax Number:

❖ MEDICATION REQUESTED

Name of Medication:	**Strength/Quantity:**	**Dose/Directions:**	**Duration of therapy:**
	OR		
J Code:	**J Units:**	**Dose/Directions:**	**Number of visits:**

❖ ICD 10 AND DIAGNOSIS

❖ Previous Medication Trials (Please include length of treatment, outcomes with dates. **Claim history or chart note documentation** showing trials of failed drugs is required. Use of drug samples cannot be accepted as justification.)

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge.

Prescriber Print Name: _____ **Date:** _____

Prescriber Signature: _____