MOLINA HEALTHCARE
Your Extended Family.

Immediate Release Opioid Prior Authorization Form

Prescribers: Please fax form to (800) 961-5160.
For provider/physician inquiries, call (855) 322-4079.

Date of Request: / /

Member Information	
Member Name:	DOB: / /
Member ID:	Gender (circle one): ☐ Male ☐ Female
Prescriber Information	
Name:	NPI:
Address:	
City/State:	Office Contact:
Phone:	Fax:
Diagnosis Information	
Diagnosis Code (ICD-10): ( )	
Acute Treatment	
Drug Name:	Strength:
Quantity:	Frequency:
Dosage form (i.e. tabs, solution):	
Which limit(s) are you requesting to exceed? ☐ >14 day supply within 45 days ☐ >60 Morphine Equivalent Dose (MED) per script	
Explanation of medical necessity for exceeding above limits:	

Chronic Treatment

If this is a continuation of treatment, describe history of regimen below.

Medication Name	Start Date	End Date	Reason for Discontinuation or Contraindication

☐ Prescriber attests that non-pharmacologic treatments and/or non-opioid analgesics were ineffective or contraindicated.

☐ Prescriber attests to OARRS review prior to writing prescription. Provide date: / /

☐ Prescriber attests that the benefits and risks of opioid therapy have been discussed with the patient.

Prescriber Signature: **Date:**