Medical Justification for a Specific Generic/Brand Medication

PLEASE FAX RESPONSE TO: (800) 869-7791

In order for Molina Healthcare to consider authorizing the prescription for the patient listed below, complete and fax this form to **(800) 869-7791**. Without this information the request may be denied.

DATE OF REQUEST	PATIENT	DATE OF BIRTH	MOLINA ID

PHARMACY	PHARMACY NPI	TELEPHONE NUMBER	FAX NUMBER

PRESCRIBER	PRESCRIBER NPI	TELEPHONE NUMBER	FAX NUMBER

DRUG/STRENGTH	DIRECTIONS FOR USE	QUANTITY / DAYS SUPPLY

In order to consider this drug request for approval, the patient MUST have had a trial of other preferred drugs, and there must be supporting clinical documentation of observed adverse reactions. Please provide the information requested below and any additional medical justification. **Attach any relevant chart notes** you have to support this patient's need for the specific medication listed above.

1. What is the diagnosis and date of diagnosis for which the drug has been prescribed?

2. What generic(s) has/have been tried?

   What were the outcomes and/or reaction?

   Length of trial?

3. What other alternatives have been tried?

   What were the outcomes and/or reaction?

   Length of trial?

4. Is there another prescriber/specialist involved with this patient's care for the same or related condition?
   Yes ☐ No ☐
   If so, please send relevant reports and recommendations.

5. Please offer any additional justification for the medical necessity for use of this specific medication for this patient.

PRESCRIBER SIGNATURE	PRESCRIBER SPECIALTY	DATE