



SPECIALTY MEDICATION REQUEST FORM

Fax Prior Authorization request to (800) 869-7791

Molina Healthcare Pharmacy Services Phone: (844) 509-7581

Patient Information					
First Name:	MI:	Last Name:	DOB:	Sex:	Member ID:
Street Address (include unit #):			City:	State:	Zipcode:
Daytime Phone:		Evening Phone:		Best Time to Contact:	
Emergency Contact Name, Relationship and Phone:					
Physician Information					
Physician Name:		Specialty:		NPI or DEA:	
Street Address (include unit #):			City:	State:	Zipcode:
Phone (include extension):			Secure Fax #:		
Medical Assessment					
For new and re-authorization requests attach current notes and related clinical information					
Diagnosis:					
Prescription Information					
Write prescription below or attach					
Drug Name, Strength and Directions:					
Number of Refills (duration):					
Physician Signature (required for processing): X				Date:	
Shipment Information					
Ship to (use address above)					
<input type="checkbox"/> Patient Home					
<input type="checkbox"/> Physician Office					
<input type="checkbox"/> Other Address (Physical Address only, no PO Boxes)					
Street Address (include unit #):					
City:		State:		Zipcode:	

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