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)

- ☐ Patient Home
- ☐ Physician Office
- ☐ Other Address (Physical Address only, no PO Boxes)

Street Address (include unit #):

City: State: Zipcode:

MRC Part #17-2927
Approvals: MHW- 9/6/17

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