Prior Authorization Request

Pharmacy Authorization

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:		
MEMBER INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Molina ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	
Phone:	Fax (required):	
Person to contact regarding this request:		
REQUESTED DRUG		
Name:	Strength:	☐ Generic substitution not permitted
Dosage:	Duration:	
PREVIOUS THERAPY		
Name:	Strength:	
Dosage:	Duration:	
CLINICAL INFORMATION		
Diagnosis and ICD-10 code (if applicable), diagnostic procedures and findings *(include dates)*:		
Medical justification for product use:		
PROVIDER CERTIFICATION – *Prescriber's signature and date required.*		
I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Molina Healthcare. **Prescriber's Signature:_____ Date: _____**		

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.