Pharmacy Prior Authorization Request Form

In order to process this request, please complete all boxes and attach relevant notes to support the prior authorization request.

Select the applicable line of business:

☐ **Molina Medicaid**
Phone: (855) 322-4079
Fax: (800) 961-5160

☐ **Molina Marketplace**
Phone: (855) 322-4079
Fax: (800) 961-5160

Patient Information

Patient Name	DOB	Date
Patient ID #	Sex	Medication Allergies
Pharmacy	Pharmacy Phone	
For Injectables Only: Facility Name	For Injectables Only: Facility NPI #	

Prescriber Information

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Office Phone	Office Contact Name

Medication Requested

Drug Name	Strength	Dose	Directions (Sig)
Duration of Prescription Days: Months:	Quantity	Number of Refills	Diagnosis
Is the patient currently treated on this medication? ☐ **Yes** ☐ **No** If yes, how long?			

Patient's Previous Medication(s) Relevant to this Request

Indicate previous treatment and outcomes below. Please attach a list if there are more than five medications.

Drug Name	**Strength**	**Dose**	**Directions**	**Duration & Reason for Discontinuation**
1				
2				
3				
4				
5				

Medical Rationale for Request/Additional Clinical Information (including diagnostic studies and lab results)

Provider Signature:_____ Date of Signature:_____