

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

 Plan/Medical Group Name: Molina Healthcare of California

 Plan/Medical Group Phone#: (888) 665-4621

 Plan/Medical Group Fax#: (866) 508-6445

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.					
Patient Information: This must be filled out completely to ensure HIPAA compliance					
First Name:		Last Name:		MI:	Phone Number:
Address:			City:		State: Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____		Allergies:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:		
Insurance Information					
Primary Insurance Name:			Patient ID Number:		
Secondary Insurance Name:			Patient ID Number:		
Prescriber Information					
First Name:		Last Name:		Specialty:	
Address:		City:		State:	Zip Code:
Requestor (if different than prescriber):			Office Contact Person:		
NPI Number (individual):			Phone Number:		
DEA Number (if required):			Fax Number (in HIPAA compliant area):		
Email Address:					
Medication / Medical and Dispensing Information					
Medication Name:					
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____					
How did the patient receive the medication? <input type="checkbox"/> Paid under Insurance Name: _____ Prior Auth Number (if known): _____ <input type="checkbox"/> Other (explain): _____					
Dose/Strength:	Frequency:		Length of Therapy/#Refills:		Quantity:
Administration: <input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____					
Administration Location:		<input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care			

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Patient Name:	ID#:
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1. Has the patient tried any other medications for this condition? YES (if yes, complete below) NO		
Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy
2. List Diagnoses:		ICD-9/ICD-10:
3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization review.		
<p>Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions) or required under state and federal laws.</p> <p><input type="checkbox"/> Attachments</p>		

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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Plan Use Only: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Date of Decision: _____	Comments/Information Requested: _____
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