



Molina Healthcare of Florida
Medication Prior Authorization / Exceptions
Request Form
 Fax: (866) 236-8531

To ensure a timely response, please fill out form **COMPLETELY** and **LEGIBLY**. An incomplete form will be returned. Requests will not be processed if any of the following information below is missing (when applicable). For any questions, please contact Molina by phone at: (866) 472-4585.

Today's Date:	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Marketplace (Exchange Plans)
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Member Information

Last Name:	First Name:
ID Number:	Date of Birth:

Provider Information

Name:	Specialty and NPI number:
Phone Number:	Fax Number:

Review Type:	<input type="checkbox"/> Discharge Planning (please provide date of discharge ___ / ___ / ___) Discharging facility (_____) Point of Contact / Case manager name and phone number (_____ / _____)
	<input type="checkbox"/> Initial Review
	<input type="checkbox"/> Reauthorization (recent clinical chart notes showing evidence of Clinical efficacy must be submitted)

*****Please submit chart notes that includes clinical information to support medical necessity of the request*****

- Medication Requested:** (Include name, strength, directions and quantity)

- Estimated duration of therapy:**

- ICD-10 Code/Diagnosis description for requested medication:**

- Previous formulary medication trial and failures:** (Length of treatment/outcome with dates must be supported in clinical documentation (chart notes). Use of pharmaceutical samples cannot be accepted as justification.)

*****HIPAA Confidentiality Notice*****

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