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:	☐ **Medicaid** ☐ **Marketplace** (Exchange Plans)

Member Information

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

Provider Information

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

Review Type:	☐ **Discharge Planning (please provide date of discharge ___/___/___)** **Discharging facility (_____)** **Point of Contact / Case manager name and phone number** **(_____/_____)**
☐ Initial Review	☐ 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******

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

2. **Estimated duration of therapy:**

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

4. **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.)