Molina Healthcare of Illinois

Pharmacy Prior Authorization Request Form

For Pharmacy PA Requests, Fax: (855) 365-8112

Patient Name	DOB	Date
Patient ID #	Sex	Medication Allergies
Pharmacy	Pharmacy Phone	
This Form is NOT for buy and bill	Pharmacy Fax	

Provider Information

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

Medication Requested Molina Healthcare is a mandatory generic plan.

Drug Name	Strength	Dose Directions (Sig):
Qty _____ Refills _____	ICD-10 & Diagnosis Name	
Is the Patient currently treated on this medication? ☐ Yes; How long? _____ No ☐		

Patient Previous Medication(s) Relevant to this Request

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

Medical Rationale for Request/Additional Clinical Information (Including diagnostic studies, lab results, & progress notes)	
Provider Signature	Date

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