



# Drug Prior Authorization Form

Medicaid Phone: (888) 898-7969  
 Michigan Marketplace Phone: (855) 322-4077  
 Wisconsin Marketplace Phone: (855) 326-5059  
 Fax: (888) 373-3059

**Please make copies for future use.**

Date of Request:	Patient DOB:
Patient Name (Last):	(First):
Patient ID (10 digit):	Name of Person Completing form:
Provider's Name and Specialty:	Provider's Address:
Phone #: (Area Code) (Number)	Fax #: (Area Code) (Number)

**Hospital Discharge**
                 
  **New Request**
                 
  **Reauthorization**

- Caremark Specialty Injectables/Non-Formulary Medications: Progress notes
- Cholesterol lowering (ie. Crestor, Vytorin, Zetia, Lovaza): Lipid Panel drawn within the last 90 days
- Diabetes (ie. Actos, Januvia): A1c Report drawn within the last 90 days
- Proton Pump Inhibitor (BID dosing only): Endoscopy Report
- Pain Management: Medication Log, Progress Notes

**Drug Requested: One drug request per form**

Name	Strength	Dose	Quantity

**\*\*OR\*\***

J Code	ICD	Name of Treatment Facility	Tax ID of Treatment Facility	Number of Units

- Estimated length of need:
- Diagnosis:
- Previous medications prescribed and outcome:

Prior Authorization form and Formulary booklet may be found at [www.MolinaHealthcare.com](http://www.MolinaHealthcare.com)