State of Illinois
Department of Healthcare and Family Services

MOLINA HEALTHCARE

MHIL: Illinois Medicaid Pharmacy Prior Authorization Request Form

Fax this completed form to patient's health plan:

Plan/MCO	Plan PBM	Plan Phone	Plan Fax
Molina Healthcare of Illinois	**CVS Caremark**	**(855) 866-5462**	**(855) 365-8112**

Before submitting a Prior Authorization (PA) request, check for **preferred alternatives** on the current PDL found at: molinahealthcare.com/providers/il/medicaid/drug/formulary.aspx

A) Reason for Request: ☐ Initial Authorization Request ☐ Renewal Request

B) Medication Billed Through (please ensure PA request is faxed to the correct department)

☐ Pharmacy Benefit ☐ Medical Benefit (Physician Administered) ☐ Unknown

C) Patient Demographics:

Patient Name: _____ DOB: _____ mm/dd/yyyy

9-Digit Health Plan Member ID # (required): ☐☐☐☐☐☐☐☐☐ MCO (if applicable): _____

Is patient hospitalized: ☐ YES ☐ NO

Discharge Date: _____ mm/dd/yyyy

PROVIDER STAMP HERE IF DESIRED

D) Prescribing Provider Information:

All prescribers must be enrolled in the Medicaid Prescribers IMPACT system:

Provider Name: _____ NPI: _____ Specialty: _____

Contact Name: _____ Contact Phone: _____

Contact Email (optional): _____ Contact Fax: _____

E) Pharmacy Information - Required if the Pharmacy is the requesting provider:

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Fax: _____ Pharmacy NPI (optional): _____

F) Representation:

I represent to the best of my knowledge and belief that the information provided is true, complete, and fully disclosed. A person may be committing insurance fraud if false or deceptive information with the intent to defraud is provided.

Provider Name: _____

Provider Signature: _____ Date: _____ mm/dd/yyyy

Prior authorization alone is not a guarantee of benefits or payment. Actual availability of benefits is always subject to other requirements of the health plan, such as limitations and exclusions, and eligibility at the time services are provided. The applicable terms of a patient's plan control the benefits that are available. At the time the claims are submitted, they will be reviewed in accordance with the terms of the plan.

Patient Name: _____ 9-Digit Health Plan Member ID#: ☐☐☐☐☐☐☐☐☐

MHIL: Illinois Medicaid Pharmacy Prior Authorization Request Form (cont.)

G) **Requested Prescription Information (**for additional requests, attach a separate copy of this page)

Drug Name: _____ Strength: _____

Dosage Form: _____ Quantity: _____ Day Supply: _____

Dosing Frequency: _____ Duration of Therapy: _____

NDC (if available): _____ HCPCS Code (if medical billing): _____

Start Date of this Request: _____
mm/dd/yyyy

Diagnosis (specific): _____

Diagnosis ICD-10 (if available): _____

Has the patient already started the medication? ☐ YES ☐ NO Date Started: _____
mm/dd/yyyy

Place of infusion/injection (if applicable): _____

Facility/Provider/TIN (if applicable): _____

H) **Rationale for Prior Authorization** (e.g., history of present illness, past medical history, current medications, etc.). **Important**: Please attach chart notes to support the request.

Medicaid providers are strongly encouraged to use equally efficacious and cost-saving preferred agents whenever possible. Previous medications used must be reflected in paid pharmacy claims.

I) **Failed/Contraindicated Therapies:** (Include drug name, strength, dosing schedule, duration, and reason for discontinuation or contraindication).

J) **Will any current medications for this indication be discontinued if this drug is approved?**
If so, list below:

K) **Specific goals of therapy/clinical benefit and other pertinent information:**
(e.g., relevant diagnostic labs, measures, response to treatment, etc.)

L) **Supplemental Information:** Certain medications will require supplemental information to complete the request review. Please refer to the plan's website for additional information that may be necessary for review. Note that sending this form with insufficient clinical information may result in an extended review period or adverse determination. Plans may require additional information based on the type of drug being requested that may require follow-up inquiries with the prescriber.

Patient Name: _____ 9-Digit Health Plan Member ID#: | | | | | | | | | | |