MISSISSIPPI STANDARDIZED PRIOR AUTHORIZATION REQUEST FORM FOR PRESCRIPTION DRUG BENEFITS

SECTION I — SUBMISSION

Submitted to: Molina Pharmacy Prior Authorization Department	Phone: 1-844-826-4335	Fax: 1-844-312-6371	Date:

SECTION II — REVIEW

☐ Expedited/Urgent Review Requested: By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐Male ☐Female Other Unknown	
Address:	City:		State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

SECTION IV — PRESCRIBER INFORMATION

Name:	NPI#:	Specialty:		
Address:	City:		State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

SECTION V — PRESCRIPTION DRUG INFORMATION

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:
☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated:_____)

For Provider Administered Drugs only:
HCPCS Code:_____ NDC#:_____ Dose Per Administration:_____

MOLINA HEALTHCARE

SECTION VI — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:

Ingredient	NDC#	Quantity	Ingredient	NDC#	Quantity

SECTION VII — PRESCRIPTION DEVICE INFORMATION

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

SECTION VIII — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION IX — JUSTIFICATION (SEE INSTRUCTION PAGE SECTION IX)