Molina Healthcare of Florida
Medication Prior Authorization / Exceptions Request Form
Fax form to: (866) 236-8531

To ensure a timely response, please fill out form completely and legibly. An incomplete form may be returned. Please submit clinical information as needed to support medical necessity of the request. Requests will not be processed if any of the following information is missing: member information, provider information or clinical documentation (chart notes). 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 & NPI number**:
Phone Number:	**Fax Number**:

Review Type:	☐ Discharge Planning (please provide date of discharge ___/___/___)
☐ Initial Review	☐ Reauthorization **(recent clinical documentation showing evidence of Clinical efficacy must be submitted)**

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.)