



**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:	<input type="checkbox"/> Medicaid <input type="checkbox"/> Marketplace (Exchange Plans)
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**Member Information**

Last Name:	First Name:
ID Number:	Date of Birth:

**Provider Information**

Name:	Specialty & NPI number:
Phone Number:	Fax Number:

<b>Review Type:</b>	<input type="checkbox"/> Discharge Planning (please provide date of discharge ___ / ___ / ___ )
<input type="checkbox"/> Initial Review	<input type="checkbox"/> Reauthorization (recent clinical documentation showing evidence of Clinical efficacy must be submitted)

- Medication Requested:** (Include name, strength, directions and quantity)
  
- Estimated duration of therapy:**
  
- ICD-10 Code/Diagnosis description for requested medication:**
  
- 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.)

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