MOLINA HEALTHCARE

MyCareOhio
Connecting Medicare + Medicaid

Pharmacy Prior Authorization Request Form

MyCare Ohio-Medicaid

Phone: (855) 322-4079 Fax: (800) 961-5160

In order to process this request, please complete all boxes and attach relevant notes to support the prior authorization request.

Patient Information

Patient Name	DOB	Date
Patient ID #	Sex	Medication Allergies
Pharmacy	Pharmacy Phone	
For Injectables Only: Facility Name	For Injectables Only: Facility NPI #	

Prescriber Information

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Office Phone	Office Contact Name

Medication Requested

Drug Name	Strength	Dose	Directions (Sig)
Duration of Prescription Days: Months:	Quantity	Number of Refills	Diagnosis
Is the patient currently treated on this medication? ☐ Yes ☐ No If yes, how long?			

Patient's Previous Medication(s) Relevant to this Request

Indicate previous treatment and outcomes below. Please attach a list if there are more than five medications.				
Drug Name	**Strength**	**Dose**	**Directions**	**Duration & Reason for Discontinuation**
1				
2				
3				
4				
5				

Medical Rationale for Request/Additional Clinical Information (including diagnostic studies and lab results)

Provider Signature: _____ Date of Signature: _____