Drug Prior Authorization Form

Michigan Medicaid and Marketplace
Phone: (855) 322-4077
Fax: (888) 373-3059

Please make copies for future use.

Date of Request:	Patient DOB:
Patient Name (Last):	(First):
Patient ID (10 digit):	Name of Person Completing form:
Provider's Name and Specialty:	Provider's Address:
Phone #: (Area Code) (Number)	Fax #: (Area Code) (Number)

☐ **Hospital Discharge** ☐ **New Request** ☐ **Reauthorization**

☐ Caremark Specialty Injectables/Non-Formulary Medications: Progress notes
☐ Cholesterol lowering (ie. Crestor, Vytorin, Zetia, Lovaza): Lipid Panel drawn within the last 90 days
☐ Diabetes (ie. Actos, Januvia): A1c Report drawn within the last 90 days
☐ Proton Pump Inhibitor (BID dosing only): Endoscopy Report
☐ Pain Management: Medication Log, Progress Notes

Drug Requested: ***One drug request per form***

Name	Strength	Dose	Quantity

****OR****

J Code	ICD	Name of Treatment Facility	Tax ID of Treatment Facility	Number of Units

- Estimated length of need:
- Diagnosis:
- Previous medications prescribed and outcome:

Prior Authorization form and Formulary booklet may be found at www.MolinaHealthcare.com