Mountain Pacific Quality Health

Request for Medicaid Home Infusion Therapy Prior Authorization

This form is only for S codes. Please type or print.

Home IV Contact Person			
Patient Name (Last, First, Middle Initial)		**Medicaid Number**	**Date of Birth**
Physician Name	**Physician Address, City, State, ZIP Code**		**Physician Telephone and Fax**
Pharmacy NPI	**Pharmacy Name**		**Pharmacy Telephone and Fax**
Pharmacy Street Address, City, State, ZIP Code			
Date Therapy Initiated:	**Is this an extension of an existing prior authorization?** Yes ☐ No ☐		
Pertinent Information (C&S, chart notes, etc.) Attached ☐			
Diagnosis and Additional Comments			

Services to be Prior Authorized

	From	Through	Service Code	Modifier Code	Days	Drug Requested
1.						
2.						
3.						
4.						
5.						

Mail or fax completed form to: Drug Prior Authorization Unit, Mountain Pacific Quality Health (MPQH), P.O. Box 5119, Helena, MT 59604 or (406) 513-1928 or (800) 294-1350.

For questions, contact MPQH: (406) 443-6002 or (800) 395.7961

Drug Prior Authorization Unit Use Only

Reason for denial of therapy prior authorization:					
Important Note: In evaluating requests for prior authorization, the consultant will consider the therapy from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to verify Medicaid eligibility. **Current member eligibility may be verified by calling Montana Provider Relations at 1(800) 624-3958 or (406) 442-1837.**					
Approval or Denial Status	**Approval or Denial Code**	**Therapeutic Class**	**Authorization ID**	**Date of Request**	**Prior Authorization Number**