Mountain-Pacific Quality Health

Request for Medicaid Home Infusion Therapy Authorization

Please type or print.

Home IV Contact Person			
Patient Name (Last, First, MI)		**Medicaid Number**	**Date of Birth**
Physician Name	**Address, City, State, ZIP**		**Telephone / Fax**
Provider NPI/API	**Provider Name**		**Telephone / Fax**
Street Address, City, State, ZIP			

Date Therapy Initiated	Is this an extension of an existing prior authorization? ☐ Yes ☐ No

Pertinent Information (C&S, chart notes, etc.) ☐ **Attached**

Diagnosis / Additional Comments

Services to be Authorized

From	Through	Procedure	Days	Therapy
1.				
2.				
3.				
4.				
5.				

Mail or fax completed form to:

Drug Prior Authorization Unit
Mountain-Pacific Quality Health
3404 Cooney Drive, Helena, MT 59602
406.443.6002 or 1.800.395.7961 Phone
406.513.1928 or 1.800.294.1350 Fax

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 Xerox State Healthcare, LLC, at 1.800.624.3958 or 406.442.1837.**

Approval/Denial Status	Approve/Deny Code	Therapeutic Class	Authorization ID	Date of Request	Prior Authorization Number