



**Mountain-Pacific Quality Health  
Request for Medicaid Drug Prior Authorization**

Please Type or Print

<b>Patient Name (Last)</b>			<b>(First)</b>			<b>(MI)</b>					
<b>Medicaid Member Number</b>					<b>Medicaid Member DOB</b>						
<b>Physician NPI</b>		<b>Physician Phone</b>		<b>Physician Fax</b>		<b>Pharmacy NPI</b>		<b>Pharmacy Phone</b>		<b>Pharmacy Fax</b>	
<b>Physician Name</b>						<b>Pharmacy Name</b>					
<b>Street Address</b>						<b>Street Address</b>					
<b>City</b>			<b>ST</b>	<b>Zip</b>		<b>City</b>			<b>ST</b>	<b>Zip</b>	
<b>DRUG REQUESTED</b>											
<b>Drug Name</b>				<b>Strength</b>		<b>Directions</b>			<b>Diagnosis</b>		
<b>Clinical Rationale for the Requested Drug</b>											
<b>LEAVE BLANK – PA USE ONLY</b>											
<b>Date of Request</b>		<b>Status</b>		<b>Dates Covered by the Request</b>		<b>Auth ID</b>		<b>Request Number</b>			
<b>Reason for Approval/Denial of Drug Prior Authorization</b>											
<p><b>IMPORTANT NOTE:</b> In evaluating requests for prior authorization, the consultant will consider the drug 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 the service to establish the recipient's Medicaid eligibility.  <b>CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONDUENT AT 1-800-624-3958 or 406-442-1837</b></p>											
<p><b>MAIL, FAX, OR PHONE COMPLETED FORM TO: DRUG PRIOR AUTHORIZATION UNIT</b>  <b>Mountain-Pacific Quality Health 3404 COONEY DRIVE</b>  <b>HELENA, MT 59602</b>  <b>Phone: (406) 443-6002 or 1-800-395-7961</b>  <b>Fax: (406) 513-1928 or 1-800-294-1350</b></p>											