

Mountain-Pacific Quality Health Request for Medicaid Home Infusion Therapy Authorization

Note: This form is only for S Codes

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 |
| Pharmacy NPI/API | Provider Name | Telephone / Fax |
| Pharmacy Street Address, City, State, Zip | | |
| Date Therapy Initiated: | Is this an extension of an existing prior authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Pertinent Information (C&S, chart notes, etc.) | <input type="checkbox"/> Attached | |
| Diagnosis / Additional Comments | | |

Services to be 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
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 Montana Provider Relations, 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 |
|----------------------------|-----------------------|----------------------|------------------|--------------------|----------------------------------|