

Prior Authorization

Many drug products require prior authorization **before** the pharmacist provides them to the member. Requests are reviewed for medical necessity.

- To request prior authorization, providers must submit the information requested on the Request for Drug Prior Authorization form to the Drug Prior Authorization Unit. See the [Forms](#) link in the left menu on the Provider Information website.
- The prescriber (e.g., physician) or pharmacy may submit requests by mail, telephone, or fax to:

Drug Prior Authorization Unit
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602
406-443-6002 or 800-395-7961 (Phone)
406-513-1928 or 800-294-1350 (Fax)

- Requests are reviewed and decisions made immediately in most cases. Decisions on requests with special circumstances that require further peer review are made within 24 hours. Requests received after the Drug Prior Authorization Unit's regular working hours of 8 a.m. to 5 p.m., Monday through Friday, or on weekends or holidays, are considered received at the start of the next working day.
- An emergency 72-hour supply may be dispensed for emergency, after-hours, weekend, and holiday requests. Payment will be authorized by using a "3" in the Days Supply field and a value of "8" in the Prior Authorization Type Code field.

Prior Authorization for Retroactively Eligible Members

When a member is determined retroactively eligible for Medicaid, the member should give the provider a Notice of Retroactive Eligibility (160-M).

The provider has 12 months from the date retroactive eligibility was determined to bill for those services.

Retroactive Medicaid eligibility does not allow a provider to bypass prior authorization requirements.

When a member becomes retroactively eligible for Medicaid, the provider may:

- Accept the member as a Medicaid member from the current date.
- Accept the member as a Medicaid member from the date retroactive eligibility was effective.
- Require the member to continue as a private-pay member.



All prior authorization requirements must be met for retroactively eligible members.

Providers may choose whether to accept retroactive eligibility. (See the *General Information for Providers* manual, Member Eligibility and Responsibilities chapter.) All prior authorization requirements must be met to receive Medicaid payment.

When submitting claims for retroactively eligible members, attach a copy of the Notice of Retroactive Eligibility (Form 160-M) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

MHSP Prior Authorization Criteria

For a list of drugs requiring prior authorization, contact the Drug Prior Authorization Unit. (See Key Contacts.)