

March 31, 2008

# Montana Healthcare Programs Notice

## Physician, Mid-Level and Pharmacy Providers

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### Preferred Drug List (PDL): Brand Products No Longer Preferred Over Generics

Effective April 1, 2008, Montana Medicaid will no longer require brand name medications to be dispensed when generic equivalents are available on the PDL.

This notice will affect the following medications where the branded product is currently preferred over its generic equivalent:

BRAND	GENERIC
Duragesic®	Fentanyl
Omnicef®	Cefdinir
Lamisil®	Terbinafine
Proscar®	Finasteride
Wellbutrin XL®	Budeprion XL
Zocor®	Simvastatin
Zofran®	Ondansetron

Providers will be allowed to use up their existing stock of these branded products as inventories are adjusted to comply with this change in policy. Prior authorization will be required.

The prescriber or pharmacy may submit requests by mail, telephone, or fax to:

**Drug Prior Authorization Unit**  
**Mountain Pacific Quality Health Foundation**  
**3404 Cooney Drive**  
**Helena, MT 59602**  
**(406) 443-6002 or (800) 395-7961 (Phone)**  
**(406) 443-7014 or (800) 294-1350 (Fax)**

To request prior authorization, providers must submit the information requested on the attached Request for Drug Prior Authorization Form to the Drug Prior Authorization Unit.

Any questions regarding this notice can be directed to Wendy Blackwood at (406) 444-2738 or the Medicaid Drug Prior Authorization Unit at (406) 443-6002.

## **Contact Information**

For claims questions or additional information, contact Provider Relations:

**Provider Relations toll-free in- and out-of-state: 1-800-624-3958**

**Helena: (406) 442-1837**

**E-mail: [MTPRHelpdesk@ACS-inc.com](mailto:MTPRHelpdesk@ACS-inc.com)**

Visit the Provider Information website:

**<http://www.mtmedicaid.org>**

# MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION

## Request for Drug Prior Authorization

Submitter:  Physician  Pharmacy

Please Type or Print

PATIENT NAME (Last) (First) (Initial)			PATIENT MEDICAID I.D. NUMBER		DATE	OF	BIRTH		
					MONTH	DAY	YEAR		
PHYSICIAN NPI		PHYSICIAN PHONE #		DATES COVERED BY THIS REQUEST					
				FROM		TO			
PHYSICIAN NAME				MONTH	DAY	YEAR	MONTH	DAY	YEAR
PHYSICIAN STREET ADDRESS				<b>MAIL, FAX OR PHONE COMPLETED FORM TO:</b>  <b>DRUG PRIOR AUTHORIZATION UNIT</b> <b>MOUNTAIN-PACIFIC QUALITY HEALTH</b> <b>3404 COONEY DRIVE</b> <b>HELENA, MT 59602</b>  <b>(406) 443-6002 or 1-800-395-7961 (PHONE)</b> <b>(406) 443-7014 or 1-800-294-1350 (FAX)</b>					
PHYSICIAN CITY STATE ZIP									
PHARMACY NPI		PHARMACY PHONE #							
PHARMACY NAME									
PHARMACY STREET ADDRESS									
PHARMACY CITY STATE ZIP									
<b>DRUG TO BE AUTHORIZED</b>									
DRUG NAME				STRENGTH		DIRECTIONS			
DIAGNOSIS OR CONDITION TREATED BY THIS DRUG									

<b>LEAVE BLANK - PA UNIT USE ONLY</b>					
REASON FOR DENIAL OF DRUG PRIOR AUTHORIZATION					
IMPORTANT NOTE: 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 service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.					
CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837.					
APPROVAL OR DENIAL STATUS	DENIAL CODE	THERAPEUTIC CLASS	AUTH ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER