



Medical Services Department
130 Neill Ave
Helena, MT 59601
Telephone: (800) 290-3657
Fax: (406) 457-2298

Medication Prior Authorization Form

Fax completed form to:
406-457-2298

Member ID #: _____

Last Name: _____ First Name: _____

Prescribing Provider Name: _____

Physician phone number: _____ Fax number: _____

Contact Person at Prescribing Provider Office _____

Medication (including dose): _____

Start Date: _____ End Date: _____ Quantity: _____

Diagnosis: _____

Specific Reason(s) for Need of Non-Formulary, greater than quantity limits or medication requiring prior authorization:

ATTACH MEDICAL RECORDS IF APPROPRIATE

Signature Attending: _____

Date: _____