

MONTANA PRESCRIPTION DRUG REGISTRY
MONTANA BOARD OF PHARMACY

P.O. Box 200513 (301 S. Park, 4th Floor – Delivery) Helena, MT 59620-0513
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AGENCY REPRESENTATIVE REQUEST FOR ONLINE ACCESS

INSTRUCTIONS:

Direct online access to the Montana Prescription Drug Registry (MPDR) may be granted to a designated representative of the Montana Medicare or Medicaid programs, Tribal Health, Indian Health Service, and Veterans Administration. **NOTE: If you have a Montana license and authority to prescribe or dispense controlled substances, you must register as a Practitioner, not as an Agency Representative.** To access registry information, each Agency Representative must first:

1. Successfully complete the board's online educational program.
2. Complete this Request Form / Confidentiality Agreement and submit it to the Montana Board of Pharmacy at the address, fax# or email address given above.
3. Submit proof of identification (a copy of your driver's license, passport or other government-issued photo identification).

MPDR Staff will independently verify that you represent your Agency. Access is granted only to individuals, not to organizations. Each individual within an Agency must apply separately to gain access to the MPDR, and each user will be issued one ID and password for their use, regardless of where they are physically located. In other words, an Agency Representative who works at multiple locations will receive one ID/password for use at all of their work locations.

AGENCY REPRESENTATIVE INFORMATION:

Please print or type.

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Social Security Number or Foreign ID: _____

Date MPDR training program was completed: _____ My DEA# (if applicable): _____

AGENCY INFORMATION:

This section should include contact information for the agency location where you spend the majority of your working hours. The email address listed in this section will be used for all communications from the MPDR. Please print or type.

Agency Name: _____

Agency Address: _____

City, State, Zip: _____

My Agency Phone Number: _____ My Mobile Phone#: _____

My Agency Email Address: _____

TERMS OF ACCOUNT USE AND CONFIDENTIALITY AGREEMENT:

Read and initial each of the following statements:

___ I am authorized by my agency to access the MPDR for the sole purpose of monitoring participants in the Agency's program(s).

___ I understand that I am responsible for the security and confidentiality of reports available to me and agree to use the reports only for the purpose of providing care to or evaluating care received by participants in my Agency's program(s).

___ I understand that information obtained from the MPDR can be made part of the patient's medical record and should be treated with the same confidentiality and security that I would treat any other portion of the patient's record. This information may be shared with other healthcare practitioners in my Agency caring for the patient upon that practitioner's request for medical records. This information may also be shared with members of my Agency for the purpose of evaluating quality of care and program compliance. If any person outside our Agency wishes to obtain a report, they will need to contact the MPDR directly or generate their own online report.

___ I agree not to disclose any data or protected health information to any unauthorized person or party.

___ I agree that I will not share my user account information, login name or password with any person, regardless of whether that person is also an authorized user of the MPDR.

___ I agree to notify the MPDR staff immediately (within one business day) of any changes in my professional credentials, and of any changes in my name, contact information or license status.

___ I agree to notify the MPDR staff immediately (within one business day) when I leave the place of employment identified on this application form OR when my job duties no longer relate to the MPDR.

I hereby attest that all information contained in this request form is accurate and complete. I understand the terms of access and confidentiality for the Montana Prescription Drug Registry (MPDR) and I will abide by these terms. Violation of any of the terms of this agreement may result in revocation of access to the MPDR, disciplinary action may be taken by my licensing board (if applicable), and I may be liable for a civil penalty of up to \$10,000 for each violation (MCA §37-7-1513) in addition to other sanctions provided by law.

Signature: _____ Date: _____

Print Name: _____

FOR USE BY MPDR STAFF ONLY:

Date Agency Contacted: _____ Contacted By: _____

Person Contacted / Method of Contact: _____

Source of Contact Information: _____

Application Approved: ___ Yes ___ No Determination By: _____ Date: _____

Denial Reason: _____

Notes: