MONTANA PRESCRIPTION DRUG REGISTRY
Check the history. It matters.

MONTANA PRESCRIPTION DRUG REGISTRY

MONTANA BOARD OF PHARMACY, DEPARTMENT OF LABOR & INDUSTRY

P.O. Box 200513 (301 S. Park, 4th Floor – Delivery) Helena, MT 59620-0513
Phone: (406) 841-2240 EMAIL: dlibsdmpdr@mt.gov
WEBSITE: www.MPDR.mt.gov

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 (see links on www.mpdr.mt.gov).**

To access registry information, each Agency Representative must first:

1. Successfully complete the board's online educational program, "Searching The MPDR Database," available online at www.MDPRinfo.mt.gov.
2. Complete this Request Form / Confidentiality Agreement. **Submit the application and required attachments to MPDR via email at dlibsdmpdr@mt.gov.**
   a. All applications must include proof of identification (a legible copy of your driver's license, passport or other government-issued photo identification).
   b. Pharmacists must also submit a legible copy of their license to practice.
   c. Prescribers (Physicians, Dentists, etc.) must also submit a legible copy of their license to practice AND their DEA registration.

Applicants will be notified by postal mail when their MPDR account has been created; the notification will include further instructions and security codes required for MPDR login.

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 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): _____

State issuing my license to practice (if applicable): _____ My license number (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: _____

APPLICANT'S ROLE IN THE ABOVE AGENCY - *Check one of the following:*

☐ I am a Pharmacist
☐ I am a Physician
☐ I am a Dentist
☐ I am a Naturopathic Physician
☐ I represent a Medicaid Fraud Unit
☐ I am a Physician Assistant
☐ I am a Podiatrist
☐ I am a Psychologist with Prescriptive Authority
☐ I am an APRN with Prescriptive Authority
☐ I am a Medicare or Medicaid Administrator
☐ I am an Optometrist
☐ I am a Medical Resident
☐ Other: _____

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 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 understand that information accessed and/or reviewed through the Montana Prescription Drug Registry (MPDR) program is confidential and constitutes protected health information (PHI). I am therefore responsible for the security and confidentiality of patient history reports available to me. I agree to use the reports only for the purpose of providing care to my patients and patients referred to me for care.

___ I understand that information obtained from the MPDR can be part of the patient's medical record and should be treated with the same confidentiality protection as I would treat any other patient's record.

___ I agree not to disclose any data or PHI to any unauthorized person or party.

___ I have completed the MPDR's online training program which includes information on privacy and security.

___ 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 understand that I must report any potential and/or identified misuse of MPDR searching or data to the MPDR program and/or the registered user's licensing board (Mont. Code Ann. 37-7-1513(2)).

I hereby attest that I understand the terms of access and confidentiality of the 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, 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: _____