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MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

DRUG PRIOR AUTHORIZATION

RETURN TO: ATTN: DRUG PRIOR AUTHORIZATION
MO HEALTHNET DIVISION
P O BOX 4900
JEFFERSON CITY MO 65102-4900

PLEASE PRINT OR TYPE. ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL NOT BE PROCESSED.

PHONE: (800) 392-8030 FAX: 573-636-6470

☐ INITIAL REQUEST ☐ RENEWAL REQUEST	PARTICIPANT MO HEALTHNET NUMBER
PARTICIPANT NAME	DATE OF BIRTH

DIAGNOSIS INCLUDING ICD-10 CODE (MUST PROVIDE DIAGNOSIS CONSISTENT WITH MEDICALLY ACCEPTED USE)

DATE DIAGNOSIS ESTABLISHED	REQUESTED DRUG NAME, DOSAGE FORM, STRENGTH, AND DOSING SCHEDULE

Is the patient currently taking the requested drug? ☐ YES ☐ NO

Date drug was first used: _____

DURATION OF NEED:

Current total drug regimen (including dosing schedule)

List all other medications previously tried, including dose, schedule, and length of product use.

Provide detailed reason alternatives were discontinued or not utilized.

For request for reimbursement of brand name drug: When was generic of requested drug tried and for how long?

If yes, state results in detail:

If no, state why in detail:

ATTACH ANOTHER SHEET IF ADDITIONAL DOCUMENTATION IS REQUIRED. FOR DRUG-SPECIFIC REQUIREMENTS, YOU MAY CALL 1-800-392-8030.

REQUESTING PHYSICIAN OR ADVANCE PRACTICE NURSE NAME AND TITLE	TELEPHONE NUMBER	FAX NUMBER
ADDRESS	PROVIDER SPECIALTY	PROVIDER NPI
PHYSICIAN'S OR APN'S SIGNATURE (ORIGINAL) AND TITLE		DATE SIGNED