



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.

1-800-392-8030

FAX: 573-636-6470

<input type="checkbox"/> INITIAL REQUEST	<input type="checkbox"/> RENEWAL REQUEST	PARTICIPANT MO HEALTHNET NUMBER
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PARTICIPANT NAME	DATE OF BIRTH
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DIAGNOSIS (MUST PROVIDE DIAGNOSIS CONSISTENT WITH MEDICALLY ACCEPTED USE)

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

PLEASE ALSO ATTACH A COPY OF THE MEDWATCH REPORT FORM OF ADVERSE EVENT.

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 TAXONOMY CODE	
PHYSICIAN'S OR APN'S SIGNATURE (ORIGINAL) AND TITLE	DATE SIGNED	MO HEALTHNET PROVIDER IDENTIFIER