



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
CLINICAL EDIT/STEP THERAPY AUTHORIZATION

RETURN TO: ATTN: DRUG EDIT AUTHORIZATION
 MO HEALTHNET DIVISION
 PO BOX 4900
 JEFFERSON CITY, MO 65102-4900

<p>PLEASE PRINT OR TYPE. ALL REQUIRED INFORMATION MUST BE SUPPLIED OR THE REQUEST CANNOT BE PROCESSED. 1-800-392-8030 FAX: 573-636-6470</p>			
<input type="checkbox"/> INITIAL REQUEST <input type="checkbox"/> RENEWAL REQUEST			PARTICIPANT MO HEALTHNET NUMBER
PARTICIPANT NAME		DATE OF BIRTH	
DIAGNOSIS			
REQUESTED DRUG NAME	DOSAGE FORM	STRENGTH	QUANTITY
DOSING SCHEDULE			
IS THE PATIENT CURRENTLY TAKING THE REQUESTED DRUG?			
<input type="checkbox"/> YES <input type="checkbox"/> NO			
DATE DRUG WAS FIRST USED			
DURATION OF NEED			
LIST ALL OTHER RELATED MEDICATIONS PREVIOUSLY TRIED, INCLUDING DOSE, SCHEDULE, LENGTH AND DATES OF PRODUCT USE.			
PROVIDE DETAILED REASON ALTERNATIVES WERE DISCONTINUED OR NOT UTILIZED.			
NAME OF PRESCRIBING PHYSICIAN OR APN		MO HEALTHNET PROVIDER IDENTIFIER (OR DEA NUMBER)	PROVIDER TAXONOMY CODE
ADDRESS		TELEPHONE NUMBER ()	FAX NUMBER ()
NAME OF PHARMACY AND CONTACT PERSON		MO HEALTHNET PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE
ADDRESS		TELEPHONE NUMBER ()	FAX NUMBER ()