



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
EDIT OVERRIDE AUTHORIZATION

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

PLEASE PRINT OR TYPE.
ALL REQUIRED INFORMATION MUST BE SUPPLIED OR THE REQUEST CANNOT BE PROCESSED.
 1-800-392-8030 FAX: 573-636-6470

PARTICIPANT NAME		DATE OF BIRTH	PARTICIPANT MO HEALTHNET NUMBER
<input type="checkbox"/> EARLY REFILL		<input type="checkbox"/> DOSE OPTIMIZATION	
DRUG NAME		DRUG NAME	
DOSAGE FORM		DOSAGE FORM	
STRENGTH		STRENGTH	
DOSING SCHEDULE		DOSING SCHEDULE	
QUANTITY		QUANTITY	
PREVIOUS PRESCRIBING DIRECTIONS		PRESCRIBING DIRECTIONS	
CURRENT PRESCRIBING DIRECTIONS		DATE OF LAST FILL (IF APPLICABLE)	
DATE OF LAST FILL	DATE OF THERAPY CHANGE	DURATION OF NEED/NUMBER OF REFILLS	
DIAGNOSIS (OPTIONAL FOR EARLY REFILL)		DIAGNOSIS	
REASON		DETAILED REASON FOR REQUEST	
<input type="checkbox"/> Replace a lost or stolen prescription (additional information may be requested) <input type="checkbox"/> Therapy change <input type="checkbox"/> Due to a starter dose <input type="checkbox"/> Vacation supply <input type="checkbox"/> Medically necessary (Include detailed reason) _____ _____			
NAME OF PRESCRIBING PHYSICIAN OR APN		MO HEALTHNET PROVIDER IDENTIFIER (OR DEA NUMBER)	
ADDRESS		TELEPHONE NUMBER ()	FAX NUMBER ()
NAME OF PHARMACY AND CONTACT PERSON		MO HEALTHNET PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE
ADDRESS		TELEPHONE NUMBER ()	FAX NUMBER ()