DRUG PRIOR AUTHORIZATION

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

Please print or type. All information must be supplied or the request will not be processed. Attach another sheet if additional documentation is required. For questions regarding drug specific requirements, call (800) 392-8030. Return this completed form by fax to (573) 636-6470.

Participant Information

Participant Name	Choose One: ☐ Initial Request ☐ Renewal Request
Participant MO HealthNet Number	Date of Birth

Diagnosis Information

Diagnosis (Must provide diagnosis consistent with medically accepted use)	
ICD-10 Code	Date Diagnosis Established

Requested Drug Information

If there is a generic available and this request is for a brand name drug, complete the Request for Brand Name Drug Prior Authorization form.

Drug Name, Strength and Dosing Form		
Directions		
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		

Prescriber Information

Prescriber name and specialty		Prescriber Provider NPI
Prescriber Telephone Number	Prescriber Fax Number	Prescriber Other Contact Information
Name, title and credentials of person completing form		
Telephone Number of person completing form	Fax Number of person completing form	Other contact info of person completing form:
Signature of person completing form		Date