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MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

ADHD MEDICATION PRIOR AUTHORIZATION CHILDREN LESS THAN 6 YEARS OLD

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.

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

PARTICIPANT NAME	DOB	PARTICIPANT MO HEALTHNET NUMBER

What is the requested drug name, strength, dosing form and instructions?

What is the diagnosis for use of this drug (including ICD-10 code)?

☐ ADD
☐ ADHD
☐ Other_____

What other mental health diagnoses does the patient have?

The following is required for initial review and additional information may be required for renewals, or medication changes, in the future based on the participants ADHD regimen at that time:

- **Documentation of the SIX signs & symptoms of ADHD elicited by the provider during assessment of the child.**
  - **Per DSM 5, this should include 6 signs & symptoms of inattention OR 6 signs & symptoms of hyperactivity/impulsivity.**
  - **If the child is diagnosed with the combined type of ADHD, then SIX signs & symptoms of inattention AND hyperactivity/impulsivity must be documented.**
- **The rating scales from parent(s), teachers or another setting such as Vanderbilt or Conners' Diagnostic Rating Scales.**
- **If there is no teacher, then a rating scale completed in another setting other than the home environment (such as daycare or pre-school) is required.**

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