MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

ADULT ADD/ADHD 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 AND RETURNED WITH THE ORIGINAL DRUG PRIOR AUTHORIZATION FORM.

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 ____________________________

Is the patient currently working or enrolled in school (including sheltered workshop or vocational rehab)?
☐ Yes ☐ No

What is the goal of ADHD therapy?

Is the patient's care supervised by a mental health specialist? ☐ Yes ☐ No
If yes, name and title?
If no, has the patient been seen by a mental health specialist in the last 6 months? ☐ Yes ☐ No

What other mental health diagnoses does the patient have?

Please submit the initial assessment that documents the ADD/ADHD diagnosis, six months of office progress notes and Adult ADHD rating scale. These are required for review.

- **Per DSM 5, documentation must include at least 5 signs and symptoms of inattention and/or at least 5 signs & symptoms of hyperactivity/impulsivity. There must be clear evidence that the symptoms interfere with social, academic, or occupational function, and they must be present in 2 or more settings.**

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