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MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

ANTIPSYCHOTIC PRIOR AUTHORIZATION CHILDREN LESS THAN 9 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)?

Is the plan for treatment short-term (less than 6 months) or long-term (greater than 6 months)?
Please specify:

What are the targeted signs and symptoms?

How long have these signs and symptoms been occurring?
Do they occur at home, school, or both?

What treatments have previously been tried?

Is the patient involved in any behavioral therapy? ☐ Yes ☐ No
If yes, what type and where?

If no, why not?

If the child has a diagnosis of Autism Spectrum Disorder, when was this diagnosed, and by whom?

Has the child been referred to a DMH Regional Center? ☐ Yes ☐ No
Has the child had ABA therapy? ☐ Yes ☐ No

Please also submit the following information:

- **The past 6 months of office progress notes**
- **Baseline fasting lipid levels**
- **Baseline fasting glucose level**
- **BMI percentile**

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