ATYPICAL ANTIPSYCHOTIC PRIOR AUTHORIZATION IN CHILDREN LESS THAN NINE 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. For questions call (800) 392-8030. Fax completed form to (573) 636-6470.

Participant Information

Participant Name	Date of Birth	Participant MO HealthNet Number

Requested Drug Information and Diagnosis

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

What are the requested directions?

What is the diagnosis for use of this drug?	ICD-10 Code

Plan for treatment: ☐ Short-term (less than 6 months) ☐ Long-term (greater than 6 months)
Specify treatment plan:

What are the targeted signs and symptoms?

How long have these signs and symptoms been occurring?	Do the symptoms occur at: ☐ Home ☐ School ☐ 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?

Does the child have a diagnosis of Autism Spectrum Disorder? ☐Yes ☐No
If yes, when was this diagnosed, and by whom?

Has the child been referred to a Department of Mental Health Regional Center? ☐Yes ☐No	Has the child had Applied Behavior Analysis therapy? ☐Yes ☐No

Submit the past 6 months of office progress notes, baseline fasting lipid levels, baseline fasting glucose level and BMI percentile.

Prescriber Information

Prescriber name and specialty		Prescriber Provider NPI
Prescriber Telephone Number	Prescriber Fax Number	Prescriber Other contact info
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

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March 2023