BENZODIAZEPINE PRIOR AUTHORIZATION

Submit completed form by fax to: (573) 636-6470

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 drug specific requirements or questions, call (800) 392-8030. **Submit completed form by fax to (573) 636-6470** or by mail: ATTN: Drug Prior Authorization, MO HealthNet Division, PO Box 4900, Jefferson City MO 65102-4900.

Participant Information

Participant Name	Date of Birth	Participant MO HealthNet Number

Diagnosis and Requested Product Information

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

What is the intended duration of therapy?	ICD-10 Code

Diagnosis

MO HealthNet allows one 15-day fill of a benzodiazepine for short-term use. For patients requiring long-term therapy, it is MO HealthNet Division's intent to ensure participants utilize lower risk anxiolytic agents prior to initiation of long-term, high-risk benzodiazepine therapy by requiring therapeutic trials of other lower risk anxiolytic agents first.

Long-Term Therapy Information

Has the patient had a minimum 60-day trial of buspirone, doxepin or hydroxyzine? ☐ Yes ☐ No
If yes, list drug(s) tried and dates.

Has the patient had an adequate trial of an SSRI or SNRI? ☐ Yes ☐ No
If yes, list drug(s) tried and dates:

Is the patient prescribed more than one benzodiazepine? ☐ Yes ☐ No
If yes, what is the drug name, strength, dosage form and instructions of the 2nd benzodiazepine?

Diagnosis & ICD-10 Code for 2nd benzodiazepine	Prescriber of 2nd benzodiazepine

High Risk Agent Information

Due to the high risk of adverse outcomes, additional documentation is required when filling a combination of more than three medications from the below high risk drug classes. If the participant will continue a combination of more than three medications from these classes, please address the following questions and submit progress notes documenting the medical necessity for using this combination of medications.

- **Antipsychotics**
- **Benzodiazepines**
- **Opiate dependence agents**
- **Opioids**
- **Sedative hypnotics**

List all the high risk agents you are aware the patient has filled in the past 30 days. Please include strength, dosage form, instructions and diagnosis for each.

Is more than one provider prescribing this combination of medications? ☐ Yes ☐ No	If yes, is collaboration of care occurring? ☐ Yes ☐ No

Prescriber Information

Prescriber Name and Specialty	Prescriber Provider NPI

Prescriber Telephone Number	Prescriber Other Contact Information

Person Completing Form Information

Name of Person Completing Form	Title and Credentials
Telephone Number	**Fax Number**

Signature of Person Completing Form	Date

2575-054
August 2023