MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

# OPIOID PRIOR AUTHORIZATION

**RETURN TO:** ATTN: DRUG PRIOR AUTHORIZATION
MO HEALTHNET DIVISION
P O BOX 4900
JEFFERSON CITY MO 65102-4900

**PLEASE PRINT OR TYPE. ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL NOT BE PROCESSED.**

1-800-392-8030 FAX: 573-636-6470

☐ INITIAL REQUEST ☐ RENEWAL REQUEST

PARTICIPANT MO HEALTHNET NUMBER

PARTICIPANT NAME

DATE OF BIRTH

REQUESTED DRUG NAME, DOSAGE FORM, STRENGTH, AND DOSING SCHEDULE

DIAGNOSIS INCLUDING ICD-10 CODE (MUST PROVIDE DIAGNOSIS CONSISTENT WITH MEDICALLY ACCEPTED USE)

DATE DIAGNOSIS ESTABLISHED

If cancer, what is the location and current treatment protocol?

Is the patient currently taking the requested drug? ☐ YES ☐ NO

Date drug was first used: ____________________

DURATION OF NEED:

Current total drug regimen (including dosing schedule)

What alternative therapies have been tried (please include dates and detailed reason alternatives were discontinued or not utilized)?

What is the plan to reduce the amount of opioids prescribed (tapering schedule)?

What is the plan for this patient in case of an overdose?

How often is the patient seen and assessed by the prescriber?

Is there a pain contract in place (which includes one prescriber, consequences if violated, lost meds, no early fills, informed conse, etc.)?

How often are random drug screens and pill counts being done?

For request for reimbursement of brand name drug: When was generic of requested drug tried and for how long?

If yes, state results in detail:

If no, state why in detail:

**ATTACH ANOTHER SHEET IF ADDITIONAL DOCUMENTATION IS REQUIRED. FOR DRUG-SPECIFIC REQUIREMENTS, YOU MAY CALL 1-800-392-8030.**

| REQUESTING PHYSICIAN OR ADVANCE PRACTICE NURSE NAME AND TITLE | TELEPHONE NUMBER | FAX NUMBER |
|---|---|---|
| ADDRESS | PROVIDER SPECIALTY | PROVIDER NPI |
| PHYSICIAN'S OR APN'S SIGNATURE (ORIGINAL) AND TITLE | | DATE SIGNED |

MO 886-4632 (4-19)