Mental Health America has been notified that people on MO Healthnet (formerly Medicaid) sometimes have problems getting the medications that will help them the most. The form below will allow healthcare professionals to notify MO Healthnet of problems associated with prescriptions being changed or refused outright. Please print the form, fill it out, and send to the address below. And thanks!

Missouri Department of Social Services, MO HealthNet Division

Behavioral Health Medication Form

SUBMIT TO:
ATTN: Clinical Services
MO HealthNet Division
PO Box 6500
Jefferson City, MO 65102

Phone: (573) 751-6961
Fax: (573) 522-8514
Clinical.Services@dss.mo.gov

PATIENT INFORMATION:  Patient Name ___________________________________________ MO HealthNet Number _____
Gender: _____ M _____ F           Date of Birth ____________     Diagnosis ________________________________
Requested Medication ___________________________________ Strength ___________ Quantity ______
Medication Dosing Schedule _______________________________ Currently Taking Medication? _______________________
Name of PRESCRIBING Physician: ____________________________________________________________________________
Complete Address ___________________________________________ Phone______________________________
Pharmacy Name ___________________________________________ [Address]
[Telephone]
Managed Care Organization [if known]: _____ Blue Advantage Plus of Kansas City; _____ HealthCare USA; _____!
   _____ Mercy Care Plus; _____ Harmony Health Plan
   _____ Prior Authorization required     _____ Medical Necessity required     _____ Other (please specify _______________________
   _____ Prior Approval Denied         _____ Prior Approval Delayed: _____ < 3 hrs; _____ 4-8 hrs; _____ 8-12 hrs __
   ______24-48 hrs; ______>48 hrs; ___
days

http://www.mhaem.org/Healthnet_Form.htm

10/22/2008
Total amount office staff time spent attempting to obtain authorization: _____ minutes; _____ hours

If the person was stable on a medication, how long have you been taking the drug? _______________________________

In seeking prior approval, were you asked to change the prescription to a preferred drug? _____ Yes; _____ No

Were you asked if the patient had already failed on a preferred drug? _____ Yes; _____ No;

How many drugs was the patient required to try before obtaining approval for the drug you preferred? _______________________________

Other comments:___________________________________________________________________________________________________

Please note that the information requested in this form may be provided to the MO HealthNet Managed Care without violating confidentiality laws or regulations.