

SKELETAL MUSCLE RELAXANTS

Prior Authorization Request

Carisoprodol, Chlorzoxazone, Cyclobenzaprine, Methocarbamol, and Orphenadrine

- Standard Request (72 hours)
 Expedited Request (24 hours)

If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug and Strength Requested: <input type="checkbox"/> carisoprodol _____mg <input type="checkbox"/> chlorzoxazone _____mg <input type="checkbox"/> cyclobenzaprine _____mg <input type="checkbox"/> methocarbamol _____mg <input type="checkbox"/> orphenadrine _____mg	Directions:
Quantity Dispensed:	Day Supply:
<input type="checkbox"/> Generic <input type="checkbox"/> Brand Necessary	

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New medication <input type="checkbox"/> Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.
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Clinical Information

Criteria applies to member age 65 years or older. For member less than 65 years, criteria does not apply.

Diagnosis:	Date Diagnosed:
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Please provide an attestation from the prescriber in the space below assessing the risks and benefits of therapy and desire to prescribe a muscle relaxant.

Please provide any additional information which should be considered in the space below:
