

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-833-546-1507

OR Mail request to: Pharmacy Services Prior Authorization Dept. 5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-866-399-0928 to request a 72-hour supply of medication.

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

Soma[®] (Carisoprodol)/Soma[®] Compound Note: Maximum of 30 Days Approval (120 Tablets)/365 Days

Note: Form must be completed in full. An incomplete form may be returned.

Beneficiary's Medicaid ID# Date of Birth (MM/DD/YYYY)																														
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☐ Soma® Compound										Directions										Quantity/30 Days										
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REQUIRED FOR REVIEW: All copies of medical records																			ent c	hart	note	s), a	nd th	e m	ost r	ecen	t			
cop	copies of related labs. The provider must retain copies of											all c	all documentation for five years.																	

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Approval Indications:

- Beneficiary must have failed at least two preferred skeletal muscle relaxants in the past 365 days.
- Approval limited to a one month supply (120 tablets) during a 365 day period.

Approval Period:

Maximum of 30 days approval (120 tablets)/365 days