

**MEDICATION PRIOR AUTHORIZATION REQUEST FORM**

**FAX this completed form to 1-888-865-6531**

**OR Mail request to: Pharmacy Services Prior Authorization Dept.**

**5 River Park Place East, Suite 210 | Fresno, CA 93720**

Call 1-833-705-1351 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<sup>®</sup> (Carisoprodol)/Soma<sup>®</sup> 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#**

[illegible]

**Date of Birth (MM/DD/YYYY)**

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**Beneficiary's Full Name**

[illegible]

**Prescriber's Full Name**

[illegible]**Prescriber's NPI**[illegible]

Prescriber Phone Number

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**Prescriber Fax Number**











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Pharmacy Name[illegible]**Pharmacy Medicaid Provider #**[illegible]

Pharmacy Phone Number

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**Pharmacy Fax Number**

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<input type="checkbox"/> Soma® (Carisoprodol)		
<input type="checkbox"/> Soma® Compound	<i>Directions</i>	<i>Quantity/30 Days</i>

Please indicate patient diagnosis: *(Must provide supporting documentation.)*

Please list (2) preferred skeletal muscle relaxants the patient received in the past 365 days. *(Please provide supporting clinical documentation indicating therapeutic outcome of trials and failures.)*

Drug Name: \_\_\_\_\_ Dates of Use: \_\_\_\_\_

Reason for Discontinuing: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Dates of Use: \_\_\_\_\_

Reason for Discontinuing: \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**REQUIRED FOR REVIEW:** All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.

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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