

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 (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 Full Name Prescriber's Full Name Prescriber's Full Name Prescriber Phone Number Pharmacy Name Pharmacy Medicaid Provider # Pharmacy Phone Number Dates 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: Date: REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of all documentation for five years.	Ben	eficia	arv's	Med	licaio	d ID#	ŧ						Date	of E	Birth	(MM	/DD/	YYY	Y)											
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Note: Form must be completed in full. An incomplete form may be returned.

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