

CARISOPRODOL PRIOR AUTHORIZATION REQUEST FORM



OptumRx
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 Phone: (800) 310-6826 Fax: (866) 940-7328



Today's Date

/ /

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # <input style="width: 100%;" type="text"/>	Date of Birth <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> / <input style="width: 60%;" type="text"/>
Patient's Name <input style="width: 100%;" type="text"/>	Prescriber's Name <input style="width: 100%;" type="text"/>
Prescriber's IN License # <input style="width: 100%;" type="text"/>	Specialty <input style="width: 100%;" type="text"/>
Prescriber's NPI # <input style="width: 100%;" type="text"/>	Prescriber's Signature <input style="width: 100%;" type="text"/>
Return Fax # <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 60%;" type="text"/>	Return Phone # <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 60%;" type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable): <input style="width: 100%;" type="text"/>

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Quantity	Dosage Regimen

***Note: Dose may not exceed 4 tablets per day of either 250 mg carisoprodol or 350 mg carisoprodol; approvals will be granted for up to 21 days' supply, to be used within a 90-day period, every 180 days**

PA Requirements for SOMA/VANADOM (CARISOPRODOL)

Member has an ACUTE musculoskeletal condition diagnosed within the past 60 days Yes No

Member is between 16 and 65 years of age Yes No

Member is currently utilizing meprobamate or has a history of meprobamate use in the last 90 days
 Yes No

Member is currently utilizing opioid therapy Yes No

Member is currently utilizing benzodiazepine therapy Yes No

Please choose one of the following:

Member has a history of each of the preferred non-liquid oral agents
 Drug/dose/date(s) of use: _____

Member has documented history of intolerance to ALL the preferred non-liquid oral agents
 Please explain: _____

Member has valid medical justification for the use of carisoprodol over preferred non-liquid oral agents
 Please explain: _____

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