Reset Form Print Form

United Healthcare Community Plan

FLORIDA MEDICAID

Prior Authorization

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) / /

Beneficiary's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number - -

Pharmacy Fax Number - -

☐ Soma® (Carisoprodol)	_____	_____
☐ Soma® Compound	*Directions*	*Quantity/30 Days*

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.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

02.01.2025

PROTOCOL
Soma® (Carisoprodol/Soma® Compound)

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

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