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Muscle Relaxants Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for nonpreferred muscle relaxants. Payment for nonpreferred muscle relaxants is authorized only for cases where there is documentation of previous trials and therapy failures with at least 3 preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.

Preferred

- ☐ Baclofen
- ☐ Chlorzoxazone
- ☐ Cyclobenzaprine
- ☐ Methocarbamol
- ☐ Orphenadrine ER/CR
- ☐ Tizanidine

Nonpreferred

- ☐ Amrix[x]
- ☐ Carisoprodol
- ☐ Carisoprodol/ASA
- ☐ Carisoprodol/ASA/Codeine
- ☐ Cyclobenzaprine ER×
- ☐ Other (specify):
- ☐ Dantrium
- ☐ Skelaxin
- ☐ Soma
- ☐ Zanaflex

Preferred trial 1: Drug name_____ Strength:_____
Dosage Instructions: _____
Trial date from:_____ Trial date to:_____
Specify failure: _____

Preferred trial 2: Drug name_____ Strength:_____
Dosage Instructions: _____
Trial date from:_____ Trial date to:_____
Specify failure: _____

Preferred trial 3: Drug name_____ Strength:_____
Dosage Instructions: _____
Trial date from:_____ Trial date to:_____
Specify failure: _____

Reason for use of nopreferred drug requiring prior approval: _____
_____

Other medical conditions to consider: _____
_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.