

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Cyclobenzaprine**
**Prior Authorization of Benefits (PAB) Form**
**Complete form in its entirety and fax to:**
**Prior Authorization of Benefits Center at 1-844-474-3341**
**1. PATIENT INFORMATION**
**2. PHYSICIAN INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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**3. MEDICATION**
**4. STRENGTH**
**5. DIRECTIONS**
**6. QUANTITY PER 30 DAYS**

Cyclobenzaprine	_____	_____	Specify: _____
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**7. DIAGNOSIS:** \_\_\_\_\_

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**
**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a diagnosis of acute myocardial infarction in the last 180 days
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a diagnosis of cardiac conditions (cardiac arrhythmias, heart block, congenital long QT syndrome, torsade de points), hyperthyroidism or heart failure in the last 730 days
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has a history of monamine oxidase inhibitor (MAOI) in the last 14 days

**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.

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Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.