Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
MUSCLE RELAXANTS

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT –ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___|___| Patient Name: ___________________________________ DOB: _________________

Patient Address:____

Provider NPI: |___|___|___|___|___|___|___|___|___|___|___| Prescriber Name:______________________________ Phone:________________

Prescriber Address:____ Fax:___________________

Pharmacy Name:____________________________ Address:______________________________________ Phone:________________

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy
NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: ____________________ NDC : |___|___|___|___|___|___|___|___|___|___|___||

Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants is authorized only for cases where there is documentation of previous trials and therapy failures with at least three 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
Lioresal Intrathecal
Methocarbamol
Orphenadrine ER/CR
Orphendrine/ASA/Caffeine 25/385/30
Tizanidine

Non-Preferred

☐ Amrix×
☐ Carisoprodol
☐ Carisoprodol/ASA
☐ Carisoprodol/ASA/Codeine
☐ Cyclobenzaprine ER×
☐ Dantrium
☐ Orphenadrine Compound DS
☐ Norflex
☐ Orphenadrine
☐ Orphengesic Forte
☐ Skelaxin
☐ Soma
☐ Zanaflex
☐ Other **(specify)**_____________________________________

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_________	______________________	________	__________

Diagnosis:____

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 Non-Preferred drug requiring prior approval:____

Other medical conditions to consider:____

Attach lab results and other documentation as necessary.

Prescriber Signature: ____ Date of Submission: __________________________
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.