



Request for Prior Authorization
MUSCLE RELAXANTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must complete all information above, 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.

Preferred

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

Non-Preferred

- Amrix, Carisoprodol, Carisoprodol/ASA, Carisoprodol/ASA/Codeine, Cyclobenzaprine ER Caps, Cyclobenzaprine ER, Dantrium, 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.