CARISOPRODOL PRIOR AUTHORIZATION REQUEST FORM

OptumRx
P.O. Box 25184
Santa Ana, CA, 92799
Phone: (800) 310-6826 Fax: (866) 940-7328

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Quantity	Dosage Regimen

***Note: Dose may not exceed 4 tablets per day of either 250 mg carisoprodol or 350 mg carisoprodol; approvals will be granted for up to 21 days' supply, to be used within a 90-day period, every 180 days**

PA Requirements for SOMA/VANADOM (CARISOPRODOL)

Member has an ACUTE musculoskeletal condition diagnosed within the past 60 days ☐ Yes ☐ No

Member is between 16 and 65 years of age ☐ Yes ☐ No

Member is currently utilizing meprobamate or has a history of meprobamate use in the last 90 days
☐ Yes ☐ No

Member is currently utilizing opioid therapy ☐ Yes ☐ No

Member is currently utilizing benzodiazepine therapy ☐ Yes ☐ No

Please choose one of the following:

☐ Member has a history of each of the preferred non-liquid oral agents
Drug/dose/date(s) of use:_____

☐ Member has documented history of intolerance to ALL the preferred non-liquid oral agents
Please explain:_____

☐ Member has valid medical justification for the use of carisoprodol over preferred non-liquid oral agents
Please explain:_____

CONFIDENTIAL INFORMATION

This facsimile transmission (and attachments) may contain protected health information from the Indiana Health Coverage Programs (IHCP), which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.