

id health Hawki

Request for Prior Authorization MUSCLE RELAXANTS

FAX Completed Form To 1.833.404.2392 **Prescriber Help Desk** 1.833.587.2012 Online covermymeds.com/main/

prior-authorization-forms/

(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 complete all information above. It must be legible, correct, and complete or form will be returned.				
Pharmacy NPI	Pharmacy fax		NDC	
where there is documentation of previou carisoprodol will be approved for a maxic coverage are met. *If a non-preferred low the same chemical entity at a therapeutionPreferred BaclofenMethocarba	quired for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants is authorized only for cases ation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for roved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for on-preferred long-acting medication is requested, one trial must include the preferred immediate release product of at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated. Methocarbamol Amrix* Dantrium Orphenadrine ER/CR Carisoprodol/ASA Soma Tizanidine Cyclobenzaprine ER Caps* Cyclobenzaprine ER* Other (specify) Other (specify)			
Strength	Dosage Instructions	Quantity	Days S	upply
Diagnosis: Preferred Trial 1: Drug Name		Strength D	osage Instruct	tions
Trial date from: Trial date to:			8	
Preferred Trial 2: Drug Name		Strength D	Dosage Instructions	
Trial date from: Trial date to:				
Specify failure:				
Preferred Trial 3: Drug Name				tions
Trial date from: Tr	ial date to:			
Specify failure:				
Reason for use of Non-Preferred drug requiring prior approval:				

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.