

Please note: All information below is required to process this request.

Fax to 1-844-403-1029 Mon-Sat: 7am to 7pm Central

## Soma® 250 (carisoprodol) Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required) Provider Information (required) Provider Name: Member Name: Insurance ID#: NPI#: Specialty: Date of Birth: Office Phone: Street Address: Office Fax: Office Street Address: City: State: Zip: Phone: City: State: Zip: Medication Information (required) Strength: Medication Name: Dosage Form: Directions for Use: Check if requesting brand ☐ Check if request is for continuation of therapy Clinical Information (required) Select the diagnosis below: □ Acute painful musculoskeletal condition Other diagnosis: ICD-10 Code(s): **Medication history:** Has the patient had a 6 month trial of carisoprodol 350 mg within the last 120 days? ☐ Yes ☐ No **Quantity limit requests:** What is the quantity requested per DAY? \_ What is the reason for exceeding the plan limitations? □ Titration or loading dose purposes ☐ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime) ■ Requested strength/dose is not commercially available ■ Other: Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? This request may be denied unless all required information is received. Please note:

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.

Office use only: Soma250-carisoprodol250\_SouthDakotaMedicaid\_2017May

For urgent or expedited requests please call 1-855-401-4262.

This form may be used for non-urgent requests and faxed to 1-844-403-1029.