CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT CARISOPRODOL PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

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

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

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber's Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber's Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address	Date(s) of Service: _____ Start Date: _____
Diagnosis	Diagnosis Code

Requested Medication	Quantity	Directions for Use

***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: _____

I attest the information on this form is accurate:
Physician Signature: _____ **Date:** _____

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