

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
SOMA/VANADOM (CARISOPRODOL) PRIOR AUTHORIZATION (PA) REQUEST FORM**



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



Today's Date <input type="text"/> / <input type="text"/> / <input type="text"/>		Non-Urgent <input type="checkbox"/>	Urgent <input type="checkbox"/>
Note: This form must be completed by the prescribing provider. ***All sections must be completed or the request will be returned.***			
Patient's CareSource # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>		
Patient's Name	Prescriber's Name		
Prescriber's Indiana License # <input type="text"/>	Specialty		
Prescriber's NPI # <input type="text"/>	Office Contact		
Prescriber's Fax <input type="text"/> - <input type="text"/> - <input type="text"/>	Prescriber's Phone <input type="text"/> - <input type="text"/> - <input type="text"/>		
Prescriber's Address	Date(s) of Service: _____ Start Date: _____		
Diagnosis	Diagnosis Code		
Requested Medication	Quantity	Directions for Use	
<p>*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</p>			
PA Requirements for SOMA/VANADOM (CARISOPRODOL)			
<p>Member has an ACUTE musculoskeletal condition diagnosed within the past 60 days <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Member is between 16 and 65 years of age <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Member is currently utilizing meprobamate or has a history of meprobamate use in the last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Member is currently utilizing opioid therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Member is currently utilizing benzodiazepine therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please choose one of the following:</p> <p><input type="checkbox"/> Member has a history of each of the preferred non-liquid oral agents Drug/dose/date(s) of use: _____</p> <p><input type="checkbox"/> Member has documented history of intolerance to ALL the preferred non-liquid oral agents Please explain : _____</p> <p><input type="checkbox"/> Member has valid medical justification for the use of carisoprodol over preferred non-liquid oral agents Please explain: _____</p>			

I attest the information on this form is accurate:

Physician Signature: _____

Date: _____

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-844-607-2831**.