AmeriHealth Caritas™
New Hampshire

Carisoprodol and Combination Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / ______

Patient information and medication requested

Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information

Prescriber last name:	Prescriber first name:
Prescriber address:	Prescriber representative:
Specialty:	NPI number:
Phone #:	Fax #:

Clinical history

1. For what condition is this medication being prescribed?

2. Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least 1 preferred analgesic? ☐ Yes ☐ No
If yes, please list treatment failures and provide dates:

3. Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least 2 preferred skeletal muscle relaxants? ☐ Yes ☐ No
If yes to question 3, results will be required prior to each dose for continued approval.

4. Is the prescribed duration of treatment for short-term therapy (up to three consecutive weeks at a time)? ☐ Yes ☐ No

5. Does the patient have an active substance use disorder? ☐ Yes ☐ No

6. Does the patient have a history of gastrointestinal (GI) bleeding (for aspirin-containing products only)? ☐ Yes ☐ No

Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:________________________________ Date: ________________
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.