Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
MUSCLE RELAXANTS

This form is used for both preferred and non-preferred agents.

(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 fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___||

Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants is authorized only for cases where there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. ×If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.

Preferred

Baclofen
Chlorzoxazone
Cyclobenzaprine
Lioresal Intrathecal
Methocarbamol
Orphenadrine ER/CR
Orphendrine/ASA/Caffeine 25/385/30
Tizanidine

Non-Preferred

- ☐ Amrix×
- ☐ Carisoprodol
- ☐ Carisoprodol/ASA
- ☐ Carisoprodol/ASA/Codeine
- ☐ Cyclobenzaprine ER×
- ☐ Dantrium
- ☐ Orphenadrine Compound DS
- ☐ Other **(specify)**_____
- ☐ Norflex
- ☐ Orphenadrine
- ☐ Orphengesic Forte
- ☐ Skelaxin
- ☐ Soma
- ☐ Zanaflex

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:_____

Preferred Trial 1: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Preferred Trial 2: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Preferred Trial 3: Drug Name_____ Strength_____ Dosage Instructions_____

Trial date from:_____ Trial date to:_____

Specify failure:_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

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.