Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

SKELETAL MUSCLE RELAXANTS
Prior Authorization Request
Carisoprodol, Chlorzoxazone, Cyclobenzaprine, Methocarbamol, and Orphenadrine

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug and Strength Requested:	Directions:
□ carisoprodol _____mg □ chlorzoxazone _____mg □ cyclobenzaprine _____mg □ methocarbamol _____mg □ orphenadrine _____mg	

Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Criteria applies to member age 65 years or older. For member less than 65 years, criteria does not apply.

Diagnosis:	Date Diagnosed:

Please provide an attestation from the prescriber in the space below assessing the risks and benefits of therapy and desire to prescribe a muscle relaxant.

Please provide any additional information which should be considered in the space below: