

**CARISOPRODOL PA FORM**



**Fax Completed Form to:  
866-254-0761  
For questions regarding this  
Prior authorization, call  
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients using carisoprodol 350mg longer than 3 weeks or more than two times per year must receive a prior authorization. Cyclobenzaprine, chlorzoxazone, methocarbamol and orphenadrine do not require a prior authorization.

- \*Note:**
- **Patients taking carisoprodol short term (3 weeks per year with one refill) do not require a PA.**
  - **PA will be approved if recipient is currently taking carisoprodol on a chronic basis and provider is weaning patient.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Prescriber Name					
Prescriber Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
<b>Requested Drug and Dosage:</b>  <input type="checkbox"/> CARISOPRODOL			<b>Diagnosis for this request:</b>		
<b>Qualifications for coverage:</b>					
<input type="checkbox"/> CHRONIC CARISOPRODOL RECIPIENT BEING WEANED (PLEASE INCLUDE WEANING SCHEDULE)				Dose	Frequency
<input type="checkbox"/> <i>I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</i>					
Prescriber Signature				Date	

**Part II: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

**Part III: FOR OFFICIAL USE ONLY**

Date Received				Initials:	
Approved - Effective dates of PA: From: / / To: / /				Approved by:	
Denied: (Reasons)					