SOMA 250mg PA FORM

Prior Authorization Vendor for ND Medicaid

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

ND Medicaid requires that patients using brand name Soma 250mg must use generic carisoprodol 350mg first line.

***Note: The PA will be approved if recipient fails a trial of carisoprodol 350mg.**

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	
Requested Drug and Dosage: □ SOMA 250MG	**Diagnosis for this request:**				
Qualifications for coverage:					
□ Failed skeletal muscle relaxant therapy	Start Date	End Date	Dose	Frequency	
□ *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.*					
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)	