



**SOMA 250 PA FORM**  
SD DEPARTMENT OF SOCIAL SERVICES  
MEDICAL SERVICES DIVISION

Fax Completed Form to:  
**866-254-0761**  
For questions regarding this  
Prior authorization, call  
**866-705-5391**

**SD Medicaid requires that patients receiving a new prescription for Soma 250 must meet the following criteria:**

- Patient must first use carisoprodol 350mg.

**Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy)**

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth:        /        /	

**Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy)**

PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:	
City:	FAX: (    )	Phone: (    )

**Part III: TO BE COMPLETED BY PHYSICIAN**

REQUESTED DRUG:	Requested Dosage: (must be completed)
	Diagnosis for this request:

**Qualifications for coverage:**

<input type="checkbox"/> Failed carisoprodol therapy	Start Date	End Date	Dose	Frequency
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Physician Signature:	Date:
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**Part IV: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: (    )	FAX: (    )
Drug:	NDC#:

**Part V: FOR OFFICIAL USE ONLY**

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