



FLORIDA MEDICAID
Prior Authorization
Soma® (Carisoprodol)/Soma® Compound

Note: Maximum of 30 Days Approval (120 Tablets)/365 Days
Note: Form must be completed in full. An incomplete form may be returned.

Beneficiary's Medicaid ID# [grid] Date of Birth (MM/DD/YYYY) [grid]

Beneficiary's Full Name [grid]

Prescriber's Full Name [grid]

Prescriber's NPI [grid]

Prescriber Phone Number [grid]

Prescriber Fax Number [grid]

Pharmacy Name [grid]

Pharmacy Medicaid Provider # [grid]

Pharmacy Phone Number [grid]

Pharmacy Fax Number [grid]

Medication selection table with checkboxes for Soma® (Carisoprodol) and Soma® Compound, and fields for Directions and Quantity/30 Days.

Please indicate patient diagnosis: (Must provide supporting documentation.)

Please list (2) preferred skeletal muscle relaxants the patient received in the past 365 days. (Please provide supporting clinical documentation indicating therapeutic outcome of trials and failures.)

Drug Name: \_\_\_\_\_ Dates of Use: \_\_\_\_\_

Reason for Discontinuing: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Dates of Use: \_\_\_\_\_

Reason for Discontinuing: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to: Magellan Medicaid Administration, Inc. Prior Authorization P. O. Box 7082 Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078

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FLORIDA MEDICAID  
**PROTOCOL**  
**Soma<sup>®</sup> (Carisoprodol/Soma<sup>®</sup> Compound)**

(Maximum of 30 days approval [120 tablets]/365 days)

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**Approval Indications:**

- Beneficiary must have failed at least two preferred skeletal muscle relaxants in the past 365 days.
- Approval limited to a one month supply (120 tablets) during a 365 day period.

**Approval Period:**

- Maximum of 30 days approval (120 tablets)/365 days