Reset Form Print Form

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#

Date of Birth (MM/DD/YYYY) / /

Beneficiary's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number - -

Pharmacy Fax Number - -

☐ Soma® (Carisoprodol) _____ _____

☐ Soma® Compound *Directions* *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

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