PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Muscle Relaxants

Phone: 800-728-7947 Fax back to: 866-880-4532

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Which medication is being requested?

- ☐ Carisoprodol
- ☐ Chlorzoxazone
- ☐ Methocarbamol
- ☐ Orphenadrine Citrate ER
- ☐ Other

Q2. What indication will the requested medication be used for?

- ☐ Acute, painful musculoskeletal conditions
- ☐ Other (Please explain)

Q3. Please provide ICD code(s) for indication being treated.

Q4. Is member greater than or equal to 65 years?

☐ Yes ☐ No

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Q5. The requested medication has been identified by CMS as a high-risk medication when used in patients age 65 and older. The prescriber should consider the risks and benefits of treatment prior to initiating therapy. Ongoing monitoring for adverse effects and reevaluation of risk versus benefit should be considered for continuation of therapy as the risks increase with patient age.
Q6. Additional comments:

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function