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# New Hampshire Medicaid Fee-for-Service Program
## Prior Authorization Drug Approval Form
Carisoprodol and Combination Medications

**DATE OF MEDICATION REQUEST: / /**

### SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

**LAST NAME:** **FIRST NAME:**

**MEDICAID ID NUMBER:** **DATE OF BIRTH:** – –

**GENDER:** ☐ Male ☐ Female

**Drug Name:** **Strength:**

**Dosing Directions:** **Length of Therapy:**

### SECTION II: PRESCRIBER INFORMATION

**LAST NAME:** **FIRST NAME:**

**SPECIALTY:** **NPI NUMBER:**

**PHONE NUMBER:** – – **FAX NUMBER:** – – –

### SECTION III: CLINICAL HISTORY

1. For what condition is this medication being prescribed?
2. Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least one preferred analgesic? ☐ Yes ☐ No
   a. If *yes*, please list treatment failures and provide dates:
3. Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least two preferred skeletal muscle relaxants? ☐ Yes ☐ No
   a. If *yes*, please list treatment failures and provide dates:

*(Form continued on next page.)*

**Phone**: 1-866-675-7755
**Fax**: 1-888-603-7696

Review Date: 01/29/2024

Magellan Rx MANAGEMENT

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**Prior Authorization Drug Approval Form**
Carisoprodol and Combination Medications

**DATE OF MEDICATION REQUEST: / /**

**PATIENT LAST NAME:**

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

**PATIENT FIRST NAME:**

| | | | | | | | | | | | |
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**SECTION III: CLINICAL HISTORY *(Continued)***

4. Is the prescribed duration of treatment for short-term therapy (up to three consecutive weeks at a time)? ☐ Yes ☐ No
5. Does the patient have an active substance use disorder? ☐ Yes ☐ No
6. Does the patient have a history of gastrointestinal (GI) bleeding (for aspirin-containing products only)? ☐ Yes ☐ No

Provide any additional information that would help in the decision-making process. *If additional space is needed, please use another page.*

**I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.**

**PRESCRIBER'S SIGNATURE**: _____ **DATE**: _____

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