Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Carisoprodol Containing Agents (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Carisoprodol Containing Agents (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
CARISOPRODOL	CARISOPRODOL COMPOUND	CARISOPRODOL, ASPIRIN AND CODEINE PHOSPHATE
CARISOPRODOL-ASPIRIN	SOMA	

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 21 days.
   If the answer to this question is no, go to question 2.

2. Does the patient have a diagnosis of substance abuse in the last 365 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 3.

3. Is the patient greater than or equal to 16 years of age? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, denied.

4. Is the incoming request for greater than a 21 day supply? Y N
   If the answer to this question is yes, go to question 5.
   If the answer to this question is no, go to question 6.

5. Has the patient tried an alternative skeletal muscle relaxant in the last 30 days? Y N
If the answer to this question is yes, go to question 6.
If the answer to this question is no, denied.

6. Does the patient have a history of carisoprodol-containing agents prescribed by more than 2 prescribers in the last 90 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 7.

7. Does the patient have a claim for a carisoprodol-containing agent in the last 90 days? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, go to question 9.

8. Is the combined days supply for all carisoprodol-containing agents greater than 42 in the last 90 days? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 9.

9. Is the request for less than or equal to 4 tablets per day (for carisoprodol single agent products) or less than or equal to 8 tablets per day (for carisoprodol compound products)? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, denied.

10. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, approved for 21 days.

11. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
If the answer to this question is yes, approved for 21 days.
If the answer to this question is no, go to question 12.

12. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 21 days.
If the answer to this question is no, go to question 13.

13. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 21 days.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

____________________________________ ________________________
Prescriber (or Authorized) Signature Date