PRIOR AUTHORIZATION FORM SOMA®/CARISOPRODOL PRODUCTS	 Anthem. HealthKeepers Offered by HealthKeepers, Inc.

Requests for prior authorization (PA) must include patient name, Medicaid ID #, drug name and appropriate clinical information to support the request on the basis of medical necessity.
Please include all requested information; incomplete forms will delay the PA process.

The completed form may be faxed to **1-844-512-7020 for Retail Pharmacy or 1-844-512-7022 for Medical Injectables.**

All questions must be answered.

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION	
Name: (Last, First) ___________________________________	**Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ __
Date of Birth: ___ ___/___ ___/___ ___ ___ ___	**Gender:** □ **Male** □**Female**

DRUG INFORMATION	
Drug Name, Dosage Form & Strength:	Quantity Per Day:
Initial Request □ Note - Quantity Limit - **4 tablets per day**. Length of PA – **1 month** (Renewal requests will **NOT** be granted for at least 6 months following last day of previous course of therapy.)	Renewal Request □
Is the patient 16 years of age or older?	□ Yes □ No
Does the patient have an ACUTE, painful musculoskeletal condition? Please indicate diagnosis:____	□ Yes □ No
List pharmaceutical agents attempted and outcome: ____ ____ ____	

PRESCRIBER INFORMATION	
Name (print):____	**NPI Number:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___	**Fax Number:** (___ ___ ___) ___ ___ ___-___ ___ ___ ___
Signature of Prescribing Provider: ____	
PLEASE INCLUDE ALL REQUESTED INFORMATION. INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS.	

FAX TO 1-844-512-7020 for Retail Pharmacy or 1-844-512-7022 for Medical Injectables.
PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE.