IOWA Health and Human Services

Request for Prior Authorization
MUSCLE RELAXANTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants is authorized only for cases where there is documentation of previous trials and therapy failures with at least three preferred muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met. *If a non-preferred long-acting medication is requested, one trial must include the preferred immediate release product of the same chemical entity at a therapeutic dose, unless evidence is provided that use of these products would be medically contraindicated.

Preferred
- ☐ Baclofen
- ☐ Chlorzoxazone
- ☐ Cyclobenzaprine
- ☐ Methocarbamol
- ☐ Orphenadrine ER/CR
- ☐ Tizanidine
- ☐
- ☐
- ☐
- ☐
- ☐

Non-Preferred
- ☐ Amrix*
- ☐ Atmeksi
- ☐ Carisoprodol
- ☐ Cyclobenazprine ER Caps*
- ☐ Dantrium
- ☐ Ontralfy
- ☐ Soma
- ☐ Zanaflex
- ☐ Other (specify): _____

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:_____

Preferred Trial 1: Drug Name_____Strength_____Dosage Instructions_____

Trial date from:_____Trial date to:_____

Specify failure:_____

Preferred Trial 2: Drug Name_____Strength_____Dosage Instructions_____

Trial date from:_____Trial date to:_____

Specify failure:_____

Preferred Trial 3: Drug Name_____Strength_____Dosage Instructions_____

Trial date from:_____Trial date to:_____

Specify failure:_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber Signature:_____Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*