



FLORIDA MEDICAID Prior Authorization Soma[®] (Carisoprodol)/Soma[®] Compound

Note: Maximum of 30 Days Approval (120 Tablets)/365 Days
Note: Form must be completed in full. An incomplete form may be returned.

Beneficiary's Medicaid ID# <input style="width: 95%;" type="text"/>	Date of Birth (MM/DD/YYYY) <input style="width: 25%; text-align: center;" type="text"/> / <input style="width: 25%; text-align: center;" type="text"/> / <input style="width: 50%;" type="text"/>
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Beneficiary's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number

Prescriber Fax Number

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number

Pharmacy Fax Number

<input type="checkbox"/> Soma [®] (Carisoprodol)	<i>Directions</i>	<i>Quantity/30 Days</i>
<input type="checkbox"/> Soma [®] Compound		

Please indicate patient diagnosis: (Must provide supporting documentation)

Please list (2) preferred skeletal muscle relaxants the patient received in the past 365 days. (Please provide supporting clinical documentation indicating therapeutic outcome of trials and failures)

Drug Name _____ Dates of Use _____

Reason for Discontinuing: _____

Drug Name _____ Dates of Use _____

Reason for Discontinuing: _____

Prescriber's Signature _____ DATE: _____

**REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. Supporting documentation includes chart notes, progress notes, and discharge summaries.
The provider must retain copies of all documentation for five years.**

Mail or Fax Information to:
Magellan Medicaid Administration, Inc.
Prior Authorization
P. O. Box 7082
Tallahassee, FL 32314-7082
Phone: 877-553-7481
Fax: 877-614-1078

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FLORIDA MEDICAID

PROTOCOL

Soma[®] (Carisoprodol/Soma[®] Compound)

[Maximum of 30 days approval(120 tablets)/365 days]

NOTE: Form must be completed in full. An incomplete form may be returned.

Approval Indications:

- Beneficiary must have failed at least two preferred skeletal muscle relaxants in the past 365 days.
- Approval limited to a one month supply (120 tablets) during a 365 day period.

Approval Period:

- Maximum of 30 days approval (120 tablets) / 365 days

TAPERING GUIDELINES (Sample)

Short Taper	Long Taper
<p>Reduce Carisoprodol over 4 days:</p> <ul style="list-style-type: none">• 350mg TID X 1 day, then• 350mg BID X 2 days, then• 350mg QD X 1 day	<p>Reduce Carisoprodol over 9 days:</p> <ul style="list-style-type: none">• 350mg TID X 3 days, then• 350mg BID X 3 days, then• 350mg QD X 3 days