



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#

Grid for Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth (MM/DD/YYYY)

Beneficiary's Full Name

Grid for Beneficiary's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for Pharmacy Fax Number

Form for Soma (Carisoprodol) and Soma Compound with fields for Directions and Quantity/30 Days

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.

Call or Fax Information to: Florida Community Care Prior Authorization
Phone number for non-specialty Prior Authorization: 877-433-7643
Phone number for specialty Prior Authorization: 866-814-5506
Fax number for non-specialty Prior Authorization: 866-255-7569
Fax number for non-specialty Prior Authorization: 866-249-6155

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