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# | **Date of Birth (MM/DD/YYYY)** ___ / ___ / ____

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** ___ - ___ - ____

☐ Soma® (Carisoprodol) ______________________ ____________

☐ Soma® Compound *Directions* *Quantity/30 Days*

Please indicate patient diagnosis: (Must provide supporting documentation)

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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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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:**
• 350mg TID X 1 day, then	• 350mg TID X 3 days, then
• 350mg BID X 2 days, then	• 350mg BID X 3 days, then
• 350mg QD X 1 day	• 350mg QD X 3 days