

New Hampshire Medicaid Fee-for-Service Program

Prior Authorization Drug Approval Form

Carisoprodol and Combination Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION I	·													
LAST NAME:	FIRST NAME:													
MEDICAID ID NUMBER:	DATE OF BIRTH:													
GENDER: Male Female														
Drug Name:	Strength:													
Dosing Directions:	Length of Therapy:													
SECTION II: PRESCRIBER INFORMATION														
LAST NAME:	FIRST NAME:													
SPECIALTY:	NPI NUMBER:													
PHONE NUMBER:	FAX NUMBER:													
SECTION III: CLINICAL HISTORY														
1. For what condition is this medication being prescribed	d?													
2. Has the patient had a defined failure of, contraindicat	ion to, or intolerance to a trial of at least 🛛 Yes 🗌 No													
one preferred analgesic?														
a. If yes, please list treatment failures and provide d	ates:													
3. Has the patient had a defined failure of, contraindicat	ion to, or intolerance to a trial of at least 🛛 Yes 🗌 No													
two preferred skeletal muscle relaxants?														
a. If yes, please list treatment failures and provide da	tes:													
(Form continued on next page.)														





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PATIENT LAST NAME:												PATIENT FIRST NAME:												
SE	SECTION III: CLINICAL HISTORY (Continued)																							
4.	4. Is the prescribed duration of treatment for short-term therapy (up to three consecutive weeks at a time)?														6 [Yes No								
5.	Does the patient have an active substance use disorder?													ſ	☐ Yes ☐ No									

6. Does the patient have a history of gastrointestinal (GI) bleeding (for aspirin-containing products only)?

Provide any additional information that would help in the decision-making process. If additional space is needed, please use another page.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ DATE:



🗌 Yes 🦳 No

Phone: 1-866-675-7755 Fax: 1-888-603-7696