



**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 REQUESTED**

**LAST NAME:**

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**FIRST NAME:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**MEDICAID ID NUMBER:**

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**DATE OF BIRTH:**

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**GENDER:**     Male     Female

**Drug Name:**

**Strength:**

**Dosing Directions:**

**Length of Therapy:**

**SECTION II: PRESCRIBER INFORMATION**

**LAST NAME:**

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**FIRST NAME:**

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**SPECIALTY:**

**NPI NUMBER:**

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**PHONE NUMBER:**

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**FAX NUMBER:**

				-					-				
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**SECTION III: CLINICAL HISTORY**

- For what condition is this medication being prescribed?  
\_\_\_\_\_
- Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least one preferred analgesic?     Yes     No
  - If yes, please list treatment failures and provide dates:  
\_\_\_\_\_
- Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least two preferred skeletal muscle relaxants?     Yes     No
  - If yes, please list treatment failures and provide dates:  
\_\_\_\_\_

(Form continued on next page.)

