MOLINA HEALTHCARE

Musculoskeletal Therapy Agents
Carisoprodol

Please provide the information below, print your answer, attach supporting documentation, sign, date and return to our office as soon as possible to expedite this request. **Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3.** *Apple Health Preferred Drug List: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx*

Date of request: ______			
Patient ______	Date of birth ______	Molina ID ______	
Pharmacy name ______	Pharmacy NPI ______	Telephone number ______	Fax number ______
Prescriber ______	Prescriber NPI ______	Telephone number ______	Fax number ______
Medication and strength ______		Directions for use ______	Qty/Days supply ______

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   a. If yes, has the patient received carisoprodol in the last 90 days? ☐ Yes ☐ No
2. Will the patient be tapering off carisoprodol? ☐ Yes ☐ No
   a. If yes, what is the reason they will be tapering off carisoprodol?
      ☐ Concurrently taking carisoprodol with an opioid and/or benzodiazepine
      ☐ History of long-term use of carisoprodol
      ☐ Daily dose of carisoprodol exceeds 1400 mg/day
      ☐ None of the above
3. Provide a detailed description of the patients taper schedule. (Taper must be completed within 21 days.) ______
4. Indicate patient's diagnosis:
   ☐ Acute, painful musculoskeletal conditions
   ☐ Other. Specify: ______
5. Does the patient have a history of failure, contraindication, or intolerance to any of the following preferred agents? (Check all that apply)
   ☐ Baclofen
   ☐ Cyclobenzaprine

- ☐ Metaxalone
- ☐ Methocarbamol
- ☐ **Adults:** Tizanidine
- ☐ Other. Specify: ______________________

6. Will the patient be using any of the following medications concurrently? (Check all that apply.)
   - ☐ Benzodiazepines
   - ☐ Opioids
   - ☐ Other muscle relaxants
   - ☐ None of the above

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date
______________________________	___________________________	______________________________