SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Soma® (carisoprodol)/carisoprodol products) **(Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Quantity per Day: _____ **Quantity Limit** – 4 tablets per day

Length of Authorization: 1 month (Renewal requests will not be granted for 6 months following last day of previous course of therapy.)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Is member 16 years of age or older? ❑ Yes ❑ No
- Does member have an **ACUTE**, painful musculoskeletal condition? ❑ Yes ❑ No
- Member has had a trial and failure of two preferred drugs? ❑ Yes ❑ No

Please indicate diagnosis: _____

_____

(Continued on next page)

List pharmaceutical agents attempted and outcome:

_____

_____

_____

_____

_____

Medical necessity: Provide clinical evidence that the **PREFERRED** drug(s) will **not** provide adequate benefit.

_____

_____

_____

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

REVISED/UPDATED/REFORMATTED: ~~6/30/2017~~; ~~8/31/2017~~; ~~8/30/2018; 12/24/2019~~ **11/8/2023**