TEXAS MEDICAID
Clinical Edit Prior Authorization
Carisoprodol-Containing Agents & carisoprodol (SOMA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ Preferred Drug **(Go to Step 4)**

OR ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of substance abuse in the last 365 days?

   ☐ Yes (Deny) ☐ No (Go to #2)

2. Is the client greater than or equal to (≥) 16 years of age?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the incoming request for greater than (>) a 21 days supply?

   ☐ Yes (Go to #4) ☐ No (Go to #5)

4. Has the client tried an alternative skeletal muscle relaxant in the last 30 days?

   Examples of skeletal muscle relaxants include cyclobenzaprine (AMRIX ER, FEXMID), chlorzoxazone (LORZONE), metaxalone (SKELAXIN), methocarbamol (ROBAXIN), and orphenadrine ER.

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a history of carisoprodol-containing agents prescribed by more than (>) 2 prescribers in the last 90 days?

   ☐ Yes (Deny) ☐ No (Go to #6)

6. Does the client have a claim for a carisoprodol-containing agent in the last 90 days?

   ☐ Yes (Go to #7) ☐ No (Go to #8)

7. Is the combined days supply for all carisoprodol-containing agents greater than (>) 42 in the last 90 days?

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Is the request for less than or equal to (≤) 4 tablets per day (for carisoprodol single agent products) or less than or equal to (≤) 8 tablets per day (for carisoprodol compound products)?

   ☐ Yes (Approve – 21 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.