COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

DUR MEDICATION SOMA® (CARISOPRODOL)

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

PATIENT INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

Medicaid ID Number: | | | | | | | | | | | | |

Date of Birth: | | | – | | | – | | | | |

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: ______________________________

PRESCRIBER INFORMATION

Last Name: | | | | | | | | | | | | |

First Name: | | | | | | | | | | | | |

NPI Number: | | | | | | | | | | |

Phone Number: | | | | – | | | | – | | | | |

Fax Number: | | | | – | | | | – | | | | |

DRUG INFORMATION

Drug Name/Form: ____

Strength: ____

Dosing Frequency: ____

Length of Therapy: ____

Quantity per Day: ____

(Form continued on next page.)

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Patient's Last Name: | | | | | | | | | | | | |

Patient's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

SOMA® (carisoprodol) – to receive a ONE (1) month approval for this drug, complete the following questions.

Does the patient meet the following criteria?

1. Is this an Initial Request or a Renewal Request?

   ☐ Initial ☐ Renewal

   Note: Quantity Limit – Four (4) tablets per day. Renewal requests will **NOT** be granted for at least SIX (6) months following last day of previous course of therapy.

2. Is the patient 16 years of age or older?

   ☐ Yes ☐ No

3. Does the patient have an ACUTE, painful musculoskeletal condition?

   ☐ Yes ☐ No

   Please indicate diagnosis: ____

List pharmaceutical agents attempted and outcome:

____

____

____

____

____ ____________________

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060