



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Carisoprodol-aspirin-codeine Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Acute painful musculoskeletal conditions (i.e., self-limiting condition within a short time frame such as 30 days)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b><i>The approval criteria is based on the guidance provided by the Centers for Medicare &amp; Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare &amp; Medicaid Services Physician Quality Reporting System.</i></b>					
<b>Risk acknowledgment:</b>					
Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the provider wish to proceed with the originally prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.</b>					
<b>Select the medications the patient has a failure, contraindication, or intolerance to:</b>					
<input type="checkbox"/> Celebrex	<input type="checkbox"/> Celecoxib	<input type="checkbox"/> Diclofenac potassium	<input type="checkbox"/> Diflunisal	<input type="checkbox"/> EC-Naprosyn	<input type="checkbox"/> Etodolac
<input type="checkbox"/> Etodolac extended-release (ER)	<input type="checkbox"/> Fenoprofen	<input type="checkbox"/> Ibu	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Ketoprofen	<input type="checkbox"/> Meclofenamate
<input type="checkbox"/> Mefenamic acid	<input type="checkbox"/> Meloxicam	<input type="checkbox"/> Mobic	<input type="checkbox"/> Nabumetone	<input type="checkbox"/> Nalfon	<input type="checkbox"/> Naproxen
<input type="checkbox"/> Naproxen delayed-release (DR)	<input type="checkbox"/> Naproxen sodium	<input type="checkbox"/> Naproxen sodium ER	<input type="checkbox"/> Ponstel	<input type="checkbox"/> Profeno	<input type="checkbox"/> Tizanidine capsule
<input type="checkbox"/> Tizanidine tablet	<input type="checkbox"/> Vivlodex	<input type="checkbox"/> Zanaflex	<input type="checkbox"/> Zipsor	<input type="checkbox"/> Zorvolex	

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Carisoprodol-aspirin-codeine\_CMS\_2019Mar-W



## Carisoprodol-aspirin-codeine Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

### Quantity limit requests:

What is the quantity requested per DAY? \_\_\_\_\_

Does the patient's diagnosis include malignant (cancer) pain?  Yes  No

Is the medication being used to treat postoperative pain?  Yes  No

**If yes, answer the following:**

Is the medication being prescribed for pain related to a dental procedure?  Yes  No

Is the requested dose being prescribed the same dose that the patient was stable on prior to discharge?  Yes  No

Was the medication prescribed by a pain specialist or by pain management consultation?  Yes  No

**Select all of the following that have been maintained and documented in chart notes\*:**

- A description of the nature and intensity of the pain
- An appropriate patient medical history and physical examination
- An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- Appropriate dose escalation
- Ongoing, periodic review of the course of opioid therapy
- Verification that the risks and benefits of the use of the requested drug have been discussed with the patient, significant other(s), and/or guardian

### Chart documentation:

Will chart documentation be submitted to *OptumRx*<sup>®</sup> with this form, confirming the above information?  Yes  No

*\*Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

---

### Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Carisoprodol-aspirin-codeine\_CMS\_2019Mar-W