pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SKELETAL MUSCLE RELAXANTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Skeletal Muscle Relaxants** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
Facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary Name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-Preferred Medication Requested:

☐Amrix capsule	☐Dantrium capsule	☐orphenadrine ER tablet	☐tizanidine capsule
☐carisoprodol tablet	☐Fexmid tablet	☐Robaxin tablet	☐Zanaflex capsule
☐carisoprodol compound tablet	☐Lorzone tablet	☐Skelaxin tablet	☐Zanaflex tablet
☐chlorzoxazone tablet	☐metaxolone tablet	☐Soma tablet	☐_____

Strength:	Directions:	Quantity:	Refills:
Diagnosis:		Diagnosis code (*required*):	

1. Which of the following preferred agents in this therapeutic class has the beneficiary tried & failed? *Check all that apply*. ☐baclofen tablet ☐cyclobenzaprine tablet ☐dantrolene sodium capsule ☐methocarbamol tablet ☐tizanidine tablet	*Submit medical record documentation, including names, doses, and length of therapy for medications tried and failed.*
2. Does the beneficiary have a contraindication or intolerance to any of the preferred agents listed in question (1)?	☐Yes – *Submit medical record documentation of contraindications/intolerances.* ☐No

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date:**