Reset Form Print Form

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form

Carisoprodol and Combination Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. For what condition is this medication being prescribed?
2. Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least one preferred analgesic? ☐ Yes ☐ No
   a. If *yes*, please list treatment failures and provide dates:
3. Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least two preferred skeletal muscle relaxants? ☐ Yes ☐ No
   a. If *yes*, please list treatment failures and provide dates:

(Form continued on next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

4. Is the prescribed duration of treatment for short-term therapy (up to three consecutive weeks at a time)? ☐ Yes ☐ No
5. Does the patient have an active substance use disorder? ☐ Yes ☐ No
6. Does the patient have a history of gastrointestinal (GI) bleeding (for aspirin-containing products only)? ☐ Yes ☐ No

Provide any additional information that would help in the decision-making process. *If additional space is needed, please use another page.*

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-800-424-7901
Fax: 1-800-424-7984

Prime THERAPEUTICS™