

Please provide the information below, print your answer, attach supporting documentation, sign, date and return to our office as soon as possible to expedite this request.

Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082. *Apple Health Preferred Drug List: <https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx>*

Date of request: _____			
Patient _____	Date of birth _____	Molina ID _____	
Pharmacy name _____	Pharmacy NPI _____	Telephone number _____	Fax number _____
Prescriber _____	Prescriber NPI _____	Telephone number _____	Fax number _____
Medication and strength _____		Directions for use _____	Qty/Days supply _____

1. Is this request for a continuation of existing therapy? Yes No
 a. If yes, has the patient received carisoprodol in the last 90 days? Yes No

2. Will the patient be tapering off carisoprodol? Yes No
 a. If yes, what is the reason they will be tapering off carisoprodol?
 Concurrently taking carisoprodol with an opioid and/or benzodiazepine
 History of long-term use of carisoprodol
 Daily dose of carisoprodol exceeds 1400 mg/day
 None of the above

3. Provide a detailed description of the patients taper schedule. (Taper must be completed within 21 days.) _____

4. Indicate patient's diagnosis:
 Acute, painful musculoskeletal conditions
 Other. Specify: _____

5. Does the patient have a history of failure, contraindication, or intolerance to any of the following preferred agents? (Check all that apply)
 Baclofen
 Cyclobenzaprine

- Metaxalone
- Methocarbamol
- Adults:** Tizanidine
- Other. Specify: _____

6. Will the patient be using any of the following medications concurrently?
(Check all that apply.)

- Benzodiazepines
- Opioids
- Other muscle relaxants
- None of the above

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature

Prescriber specialty

Date