Updated: 09/2024
DMMA Approved: 09/2024

Request for Prior Authorization for Carisoprodol
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Carisoprodol require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Carisoprodol Prior Authorization Criteria:
Coverage may be provided with a diagnosis of acute musculoskeletal pain and the following criteria is met:

- Member is age appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- Must have tried and failed two preferred skeletal muscle relaxant medications
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines and will not exceed a max daily dosing of four times per day
- Carisoprodol should only be used for a maximum of 2 to 3 weeks due to lack of evidence of effectiveness with prolonged use
- The member will not use carisoprodol in combination with a benzodiazepine
- The member has no contraindications to the medication including acute intermittent porphyria.

- **Initial Duration of Approval:** up to 3 weeks.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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CARISOPRODOL
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8 am to 7 pm

PROVIDER INFORMATION

Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	
Member ID:	DOB:

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No	

MEDICAL HISTORY

Diagnosis: **ICD-10:** _____

Has the member tried and failed two preferred skeletal muscle relaxants? ☐ Yes ☐ No

Will the member be using carisoprodol in combination with a benzodiazepine? ☐ Yes ☐ No

Does the member have any contraindications to carisoprodol including acute intermittent porphyria? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Drug Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why / Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE FOR CONTINUATION OF TREATMENT

Prescribing Physician Signature	Date

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