



Prior Authorization Request Form – Skeletal Muscle Relaxants

Instructions:

This form is to be used by participating providers to request coverage for Skeletal Muscle Relaxant medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
 P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
 Fax: 1-800-918-7542

A Skeletal Muscle Relaxant step therapy program has been developed to encourage the use of first-line therapies before second-line therapies are used for the same indication.

First-line therapies:

chlorzoxazone
 cyclobenzaprine
 methocarbamol
 orphenadrine citrate ER
 orphenadrine/ASA/caffeine
 baclofen
 dantrolene
 tizanidine

Second-line therapies:

carisoprodol
 carisoprodol/ASA
 carisoprodol/ASA/codeine
 metaxalone

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name & Specialty: Mailing Address:	5. Contact Person at Office:
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6. Prescriber's FAX & Telephone Number:	Fax: ()	Tel: ()
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7. Requested Drug:	8. Dose, Frequency and Duration of Requested Drug:
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9. Has the member previously tried at least <u>two</u> of the following?			
Drug Name (please check all that apply)	Response (please check all that apply)		
<input type="checkbox"/> chlorzoxazone	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> cyclobenzaprine	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> methocarbamol	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> orphenadrine citrate ER or orphenadrine/ASA/caffeine	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> baclofen	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> dantrolene	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> tizanidine	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy

10. Prescriber comments:

Signature:

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