MHS PHARMACY BENEFIT
SOMA AND COMBINATIONS PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retroactive PA ☐	Date(s) of service requested for retroactive eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Quantity	Dosage Regimen

***Note: Dose may not exceed 4 tablets per day of carisoprodol; 8 tablets per day of combination products.**

PA Requirements for SOMA (CARISOPRODOL)

Member has an ACUTE musculoskeletal condition diagnosed within the past 6 months ☐ Yes ☐ No

Member is currently utilizing meprobamate or has a history of meprobomate use in the last 90 days
☐ Yes ☐ No

Member is currently utilizing opioid therapy ☐ Yes ☐ No

Member is currently utilizing benzodiazepine therapy ☐ Yes ☐ No

Please choose one of the following:

☐ Member has a history of at least 1 preferred agent in the past 30 days
Drug/dose/date(s) of use:_____

☐ Member has documented history of intolerance to the preferred agents
Please explain:_____

PA Requirements for SOMA COMPOUND/CODEINE (CARISOPRODOL/ASPIRIN/CODEINE)

Please provide medical rationale for use: