

## Skeletal Muscle Relaxants - Nebraska Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.  
Allow at least 24 hours for review.**

### Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

### Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

### Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

### Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

### Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Did the patient have a 1 week trial and failure with TWO preferred medications within this drug class?</b> <i>(If yes, complete Section D above)</i>
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**AMRIX / FEXMID**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a clinical reason why the patient cannot use IR cyclobenzaprine?</b> <i>If yes, list reason:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is this only for acute muscle spasms?</b>
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**CARISOPRODOL**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have one of the following diagnoses?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Acute, Musculoskeletal Pain <input type="checkbox"/> Chronic Pain
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the patient already had 30 days of therapy?</b>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has 6 months passed since the last day of the previous course of therapy?</b>
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**DANTROLENE**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient being treated for spasticity from spinal cord injury?</b>
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**LORZONE**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a clinical reason why the patient cannot use chlorzoxazone?</b> <i>If yes, list reason:</i>
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**SOMA 250MG**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a clinical reason why the patient cannot use the 350mg generic strength?</b> <i>If yes, list reason:</i>
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**ZANAFLEX CAPSULES**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a clinical reason why the patient cannot use the generic?</b> <i>If yes, list reason:</i>
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**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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