



**New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form**

Carisoprodol and Combination Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

				-					-				
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SECTION III: CLINICAL HISTORY

- For what condition is this medication being prescribed?

- Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least one preferred analgesic? Yes No
 - If yes, please list treatment failures and provide dates:

- Has the patient had a defined failure of, contraindication to, or intolerance to a trial of at least two preferred skeletal muscle relaxants? Yes No
 - If yes, please list treatment failures and provide dates:

(Form continued on next page.)



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Carisoprodol and Combination Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY *(Continued)*

4. Is the prescribed duration of treatment for short-term therapy (up to three consecutive weeks at a time)? Yes No
5. Does the patient have an active substance use disorder? Yes No
6. Does the patient have a history of gastrointestinal (GI) bleeding (for aspirin-containing products only)? Yes No

Provide any additional information that would help in the decision-making process. *If additional space is needed, please use another page.*

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:** _____