Prior Authorization Request Form for Skeletal Muscle Relaxant

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

For controlled Skeletal Muscle Relaxants: Did the prescriber or prescriber's delegate search the PDMP to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No *Submit documentation.*
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Skeletal Muscle Relaxants? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances.*

CHECK ALL THAT APPLY. *SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.*

Therapeutic Duplication:

If concurrently prescribed a therapeutic duplicate (i.e. skeletal muscle relaxant different from the agent being requested):

- ☐ Member is transitioned from one skeletal muscle relaxant to another with the intent of discontinuing one of the medications
- ☐ Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

Exceeds Quantity Limit:

- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

CHECK ALL THAT APPLY. *SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.*

MEMBER IS CONCURRENTLY ON BUPRENORPHINE FOR OPIOID USE DISORDER:

- ☐ The prescriptions were prescribed by the same prescriber
- ☐ The prescriptions were prescribed by different prescribers
  - ☐ All prescribers are aware of the other controlled substance prescription
- ☐ Has an **acute** need for the request skeletal muscle relaxant-specify:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)