

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR Medication Soma® (carisoprodol)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

PATIENT INFORMATION

Last Name:

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

First Name:

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

Medicaid ID Number:

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

Date of Birth:

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

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

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

First Name:

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

NPI Number:

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

Phone Number:

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

Fax Number:

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

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Patient's Last Name:

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

Patient's First Name:

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

DIAGNOSIS AND MEDICAL INFORMATION

SOMA® (carisoprodol) – to receive a ONE (1) month approval for this drug, complete the following questions.

Does the patient meet the following criteria?

1. Is this an Initial Request or a Renewal Request?

Initial Renewal

Note: Quantity Limit – Four (4) tablets per day. Renewal requests will **NOT** be granted for at least SIX (6) months following last day of previous course of therapy.

2. Is the patient 16 years of age or older?

Yes No

3. Does the patient have an ACUTE, painful musculoskeletal condition?

Yes No

Please indicate diagnosis: _____

List pharmaceutical agents attempted and outcome:

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the PA process.

Submission of documentation does NOT guarantee coverage.