



**Kansas Medical Assistance Program**  
 P O Box 3571  
 Topeka, KS 66601-3571  
 Provider 1-800-933-6593  
 Beneficiary 1-800-766-9012

**Prior Authorization for Non-Preferred Muscle Relaxants**

Preferred (Skeletal)	Non-Preferred, Prior Authorization Required
Flexeril® (cyclobenzaprine) Robaxin® (methocarbamol) Robaxin-750® (methocarbamol)	Amrix® (cyclobenzaprine ER) Fexmid® 7.5mg (cyclobenzaprine) Lorzone® (chlorzoxazone) Norflex® (orphenadrine) Norgesic® (orphenadrine/aspirin/caffeine) Norgesic® Forte (orphenadrine/aspirin/caffeine) Parafon Forte DSC® (chlorzoxazone) Skelaxin® (metaxalone)
Preferred (Spasticity)	Non-Preferred, Prior Authorization Required
Lioresal® (baclofen) Zanaflex® Tablets (tizanidine)	Dantrium® (dantrolene) Zanaflex® Capsules (tizanidine)

**Beneficiary Information**

Name: \_\_\_\_\_  
 Medicaid ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Pharmacy Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
 NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Requested Drug: \_\_\_\_\_ NDC: \_\_\_\_\_

**Prescriber Information**

Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
 NPI #: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

- Patient has a medical intolerance to preferred drug.** Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: \_\_\_\_\_
- Patient has had an inadequate response to preferred drug.** Name of preferred agent patient tried: \_\_\_\_\_
- An appropriate formulation or indication is not available as a preferred drug.** Please specify which formulation or indication is needed and information supporting the need: \_\_\_\_\_

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.  
 This form will be returned unprocessed if it is not completed in its entirety.**