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

Carisoprodol (Soma®)
Prior Authorization Request Form

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date Of Birth: ____/____/_____

Pharmacy Name: _____

Pharmacy Medicaid ID#: _____ Pharmacy NPI#: _____

Phone number: (____)_____ Fax number: (____)_____

NDC Requesting: _____

Prescribing Physician's Name: _____

Physician Medicaid ID#: _____ Physician NPI#: _____

Phone number: (____)_____ Fax number: (____)_____

Please provide the documented taper schedule: _____

_____

Is there documentation of a new muscle injury? Yes _____ No _____

Document Preferred drug tried:_____

Medical necessity for Non–Preferred drug:_____

_____

Signature of Physician or Designee: _____ Date: ____/____/_____

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