Prescriber Criteria Form

HRM Muscle Relaxants PA Plus 2026 PA Fax 3617-B v1 010126.docx
High Risk Medications (HRM) Criteria– Skeletal Muscle Relaxants
Amrix (cyclobenzaprine extended-release), carisoprodol, carisoprodol/aspirin, carisoprodol/aspirin/codeine, chlorzoxazone, cyclobenzaprine, Metaxall (metaxalone), metaxalone, methocarbamol, orphenadrine citrate extended-release, orphenadrine citrate/aspirin/caffeine
This HRM List applies to formulary drugs only.
Prior Authorization applies only to patients 65 years of age or older.
Prior Authorization applies to greater than cumulative 90 days of therapy per year.
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Skeletal Muscle Relaxants.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the relief of muscle spasm or discomfort associated with an acute, painful musculoskeletal condition? [If no, then no further questions.]	Yes	No
2	The use of this medication is potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored. Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient? [If no, then no further questions.]	Yes	No
3	Is the patient using one or more additional anticholinergic medications (e.g., oxybutynin, meclizine, paroxetine, amitriptyline, dicyclomine, hydroxyzine) with the requested drug? [If no, then no further questions.]	Yes	No
4	Has the prescriber determined that taking multiple anticholinergic medications is medically necessary for the patient?	Yes	No

	[Note: Use of multiple anticholinergic medications in older adults is associated with an increased risk of cognitive decline.]		

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____