Clinical Pharmacy Program Guidelines for Carisoprodol-Containing Agents

Program	Prior Authorization
Medication	Carisoprodol-Containing Agents

1. Background:

Drugs Requiring Prior Authorization:

CARISOPRODOL 250 MG TABLET
CARISOPRODOL 350 MG TABLET
CARISOPRODOL COMPOUND TAB
CARISOPRODOL, ASPIRIN AND CODEINE PHOSPHATE
CARISOPRODOL-ASPIRIN 200-325 MG
SOMA 250 MG TABLET
SOMA 350 MG TABLET

Coverage Criteria:

All of the following:

1) If the request is for a non-preferred medication, one of the following:
   i. Beneficiary must demonstrate failure to at least one (1) of the preferred formulary/PDL alternatives) within the last 180 days**- Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.**

   -OR-

   ii. Beneficiary must demonstrate history of contraindication, intolerance or allergy to at least one (1) of the preferred formulary/PDL alternatives for the given diagnosis

-AND-

2) Client greater than or equal to (≥) 16 years of age

Program	Program Type - Prior Authorization
Change Control	
Date	Change
December 1, 2018	New Program