CONTAINS CONFIDENTIAL PATIENT INFORMATION

Cyclobenzaprine

Prior Authorization of Benefits (PAB) Form
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 844-474-3341.

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name:_____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Cyclobenzaprine			Specify:

7. Diagnosis

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.
Note: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Patient has a diagnosis of acute myocardial infarction in the last 180 days
☐ Yes ☐ No Patient has a diagnosis of cardiac conditions (cardiac arrhythmias, heart block, congenital long QT syndrome, torsade de points), hyperthyroidism or heart failure in the last 730 days
☐ Yes ☐ No Patient has a history of monamine oxidase inhibitor (MAOI) in the last 14 days

9. PHYSICIAN SIGNATURE

_____	_____
Prescriber or authorized signature	Date

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.
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Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. *Note: Payment is subject to member eligibility. Authorization does not guarantee payment.*
The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.