Prior Authorization Request Form for
Cyclobenzaprine (Amrix)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 Please complete the clinical assessment:

1. Is Amrix being used as an adjunct to rest and physical therapy for short-term relief of muscle spasm associated with acute, painful musculoskeletal conditions?	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. Has the patient tried and failed generic immediate-release cyclobenzaprine?	☐ Yes Proceed to question 3	☐ No Coverage not approved
3. Does the patient have any of the following conditions: elderly (greater than 65 years of age); hepatic impairment; history of urinary retention; angle-closure glaucoma; increased intraocular pressure; is taking anticholinergic medications?	☐ Yes Coverage not approved	☐ No Proceed to Question 4
4. Is Amrix being prescribed for more than 3 weeks?	☐ Yes Coverage not approved	☐ No Sign and date below

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[2 November 2016]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: