TRICARE Prior Authorization Request Form for
chlorzoxazone **(Lorzone)** 375mg and 750mg

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

USFHP Pharmacy Prior Authorization Form

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. **Chlorzoxazone 500 mg tablets are scored and available without a PA. Please consider changing the prescription to the 500 mg tablets and instructing the patient to cut the tablets appropriately.** Does the prescriber acknowledge this preference?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. **Please state why the patient requires chlorzoxazone 375 mg or 750 mg and why the patient cannot take chlorzoxazone 500 mg tablet.** **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

[13 May 2020]

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