



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

Prior Authorization Request Form for
cyclobenzaprine sublingual tablets (Tonmya)

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.

Prior authorization does not expire.

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

1 Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth:	_____	Secure Fax #:	_____

Step 2 Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. What is the indication or diagnosis?	<input type="checkbox"/> Fibromyalgia based on American College of Rheumatology (ACR) diagnostic criteria – Proceed to question 3 <input type="checkbox"/> Other diagnosis – STOP – Coverage cannot be approved.	
3. Has the patient had a trial and failed one or more generic medications used to treat fibromyalgia, such as cyclobenzaprine, pregabalin, and duloxetine?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 4
4. Has the patient had intolerance to one or more generic medications used to treat fibromyalgia, such as cyclobenzaprine, pregabalin, and duloxetine?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Please provide the clinical reason as to why the patient is unable to use cyclobenzaprine tablets.	<hr/> <p style="text-align: center;">Sign and date below</p>	

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

_____	_____
Prescriber Signature	Date

[20 November 2025]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: