Prior Authorization Request Form for
tizanidine capsules **(Zanaflex)**

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HEALTH PLANS

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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. Tizanidine tablets and other formulary muscle relaxants are available to DoD beneficiaries without the need of prior authorization. Please consider changing the prescription to the tizanidine tablets or another formulary muscle relaxant.	☐ Acknowledged Proceed to question **2**
2. Please explain why the patient requires tizanidine capsules and cannot take tizanidine tablets or one of the other cost effective formulary alternatives.	______________________ **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

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