Louisiana Medicaid
Pain Management – Skeletal Muscle Relaxants

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request prior authorization for non-preferred skeletal muscle relaxants.

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- If the request is for an orphenadrine-containing agent, **BOTH** of the following are true:
  - The recipient is 18 years of age or older on the date of the request; **AND**
  - The prescriber **states on the request** that the recipient has been evaluated for drug abuse and dependence and therapy is clinically appropriate; **AND**
- If the request is for Zanaflex® 8mg capsule, the prescriber **states on the request** the patient-specific, clinically significant justification why the 4mg-formulation cannot be used; **AND**
- If the request is for a combination product containing orphenadrine, the recipient has had a *treatment failure* with single ingredient orphenadrine 100mg tablets; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy: 3 to 6 months
An appropriate duration of initial authorization and reauthorization approval (if needed) will be determined based upon patient-specific factors and the condition being treated.

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc. https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill. https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Revision / Date	Implementation Date
Single PDL Implementation	May 2019
Separated “Select Therapeutic Classes Not Established” into individual therapeutic class documents / November 2019	January 2020
Formatting changes / April 2021	July 2021
Created separate 'Continuation of Therapy' criteria, added criteria for orphenadrine-containing agents, formatting changes / March 2025	August 2025
Added clinical justification requirement for 8mg capsule requests / October 2025	April 2026