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.

~~These agents may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.~~

Approval Criteria for Initiation of Therapy~~al and Reauthorization Requests~~

- 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 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.~~;~~ ~~**AND**~~

~~By submitting the authorization request, the prescriber attests to the following:~~

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.

  - ~~The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**~~
  - ~~All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**~~

- ~~The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.~~

Duration of approval for initiation and continuation of therapy~~Duration of authorization approval~~:
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.~~;~~ ~~Retrieved from~~ 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.~~;~~ ~~Retrieved from~~ 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