



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTHORIZATION QUESTIONNAIRE-AMRIX®

*M.D. Last Name:* \_\_\_\_\_ *M.D. First Name:* \_\_\_\_\_

*Physician Phone:* \_\_\_\_\_ *Physician Fax:* \_\_\_\_\_

*Patient* \_\_\_\_\_ *ID#* \_\_\_\_\_ *DOB* \_\_\_\_\_

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

- 1. Does the patient have a hypersensitivity to any component of this product? Yes    No
- 2. Is the patient currently being treated with, or has he/she used a MAOI in the past 14 days?  
Ex. Isocarboxazid (Marplan), tranylcypromine (Parnate), phenelzine (Nardil), selegiline (Eldepryl, Emsam) Yes    No
- 3. Has the patient had a recent myocardial infarction? Yes    No
- 4. Does the patient have any cardiac arrhythmias? Yes    No
- 5. Does the patient have either heart block or conduction disturbances? Yes    No
- 6. Does the patient have congestive heart failure? Yes    No
- 7. Does the patient have hyperthyroidism? Yes    No
- 8. Has the patient tried and failed generic cyclobenzaprine 10mg? Yes    No
  - a. If Yes, provide dates of trial \_\_\_\_\_
  - b. If No, provide the rationale for non-trial \_\_\_\_\_

9. Dose requested:

- Amrix 15 mg                       Amrix 30 mg

10. Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:  
**877-526-9906**

[www.restat.com](http://www.restat.com)