

# CERTIFICATION OF NEED FOR CARISOPRODOL USE

## PARTICIPANT'S CERTIFICATION OF NEED FOR CARISOPRODOL USE

I, \_\_\_\_\_, hereby certify that I have a legitimate prescription for carisoprodol (Soma®) and understand that whereas carisoprodol is usually avoided in individuals with a history of chemical dependency, that, in order to remain compliant with my DOPL or URAP Agreement, I certify to the following:

- A. The medical condition(s) for which I take carisoprodol is(are)  
\_\_\_\_\_
- B. I have exhausted all other reasonable alternative treatments and medications for this condition and have found carisoprodol to be a necessary component of treatment which provides satisfactory relief of symptoms of the above condition.
- C. I am taking the carisoprodol exactly as prescribed by my prescriber, who is  
\_\_\_\_\_
- D. I am obtaining my prescription for carisoprodol from only a single prescriber, above named, and am filling the prescription at only a single pharmacy, which is  
\_\_\_\_\_
- E. I will submit a copy of every prescription or refill of carisoprodol that I receive to URAP or DOPL just as I am currently required to do with all mood-altering or controlled substance prescriptions.

Signature: \_\_\_\_\_ Signature Date: \_\_\_/\_\_\_/\_\_\_

*(This section to be completed by the Prescriber)*

## PRESCRIBER'S CERTIFICATION OF NEED FOR CARISOPRODOL USE

I hereby certify that I, *(name and degree)* \_\_\_\_\_ am the prescriber of carisoprodol (Soma®) to the above named patient who has informed me they suffer from the disease of chemical dependency and further verify, to the best of my understanding, the following facts:

- A. The medical condition(s) being treated is(are)  
\_\_\_\_\_
- B. All other reasonable or usual therapies used to treat this condition have been exhausted and have not produced the degree of success that the inclusion of carisoprodol in the regimen has accomplished.
- C. This patient is not receiving prescriptions for carisoprodol from anyone other than myself or my partners or associates and is filling such prescriptions at only one pharmacy as listed above.
- D. The patient is taking the carisoprodol exactly as prescribed by me and has not asked for early refills, unusual quantities or increasing amounts.

Prescriber's Signature: \_\_\_\_\_ Signature Date: \_\_\_/\_\_\_/\_\_\_