

# CERTIFICATION OF NEED FOR FLEXERIL® USE

## PARTICIPANT'S CERTIFICATION OF NEED FOR FLEXERIL® USE

I, \_\_\_\_\_, hereby certify that I have a legitimate prescription for Flexeril® and understand that whereas Flexeril® 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 Flexeril® is(are)  
\_\_\_\_\_
- B. I have exhausted all other reasonable alternative treatments and medications for this condition and have found Flexeril® to be a necessary component of treatment which provides satisfactory relief of symptoms of the above condition.
- C. I am taking the Flexeril® exactly as prescribed by my prescriber, who is  
\_\_\_\_\_
- D. I am obtaining my prescription for Flexeril® 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 Flexeril® 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 FLEXERIL® USE

I hereby certify that I, *(name and degree)* \_\_\_\_\_ am the prescriber of Flexeril® 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 Flexeril® in the regimen has accomplished.
- C. This patient is not receiving prescriptions for Flexeril® 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 Flexeril® exactly as prescribed by me and has not asked for early refills, unusual quantities or increasing amounts.

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