Compound Prior Authorization Form

This form is required for prior authorization requests for Compounds. Fax form to: 866-930-0019. No prior authorization requests for Compounds will be taken by phone.

Member Information	**Name:**	
	ID:	**DOB:**

Prescriber Information	**Name:**	
	Office Address:	
	City, State, ZIP:	**NPI:**
	Phone:	**Fax:**

Criteria For Approval - ALL Of The Following MUST Be Met For Approval:

- The Primary Active Ingredient In The Compound Is A Federal Legend Drug AND
- The Active Ingredients Are Prescribed In Therapeutic Amounts Based On FDA Approved Indications AND
- If A Compound Is Similar To A Commercially Available Product But Differs In Dosage, Dosage Form, Or Inert Ingredient (Such As Flavoring, Dye, Or Preservative), Clinical Documentation Is Required From The Prescriber Supporting The Need For The Compound AND
- If Any Ingredient In The Compound, Active or Inactive, Otherwise Requires Prior Authorization, The Member Must Meet Criteria Established For Medical Necessity For That Ingredient.

Clinical Criteria Documentation **Do Not Include Documentation That Is Not Requested On This Form**

1. List The Route Of Administration For The Compound: ☐ Oral ☐ Topical ☐ Other: _____
2. List The Member's Diagnosis Which This Compound Is Intended To Treat: _____
3. Is A Similar Commercially Available Product Available? ☐ Yes ☐ No If Yes, Indicate Why This Product Is Not Acceptable And Include The Specific Need For The Compound; List Previous Failed Therapies If Known:

_____

_____

4. Is The Active Ingredient(s) Of The Compound FDA-Approved For The Condition Being Treated In The Requested Route Of Administration? ☐ Yes ☐ No If No, Please Attach Peer-Reviewed Medical Evidence For Support.

List the NDC, name, dosage form, and QTY Of each ingredient. Each ingredient used in the compound MUST be listed. Begin the list with the covered legend drugs. Please attach an additional form if compound has greater than 10 ingredients.

Drug Name	Dosage Form	QTY

List any agents already trialed for this diagnosis:

Prescriber Signature:	**Date:**