# Multi-Ingredient Compound Prior Authorization Form

Pharmacy Fax Number: 1-866-930-0019 ☐ Standard ☐ Urgent

**Note:** No prior authorization requests for compounds will be taken by phone.

**MEMBER INFORMATION** Date: _____

| | |
|---|---|
| Member First Name | Member Last Name |
| HAP CareSource Member ID | Member Date of Birth |
| Member Height | Member Weight ☐ lbs ☐ kg |

**PRESCRIBER INFORMATION**

| | |
|---|---|
| Prescriber First Name | Prescriber Last Name |
| Office Address | |
| National Provider Identifier (NPI) | Office Contact Name |
| Prescriber Phone | Prescriber Fax |

**CRITERIA FOR APPROVAL**

Refer to the Pharmacy Multi-Ingredient Compound Policy available at **HAPCareSource.com**. Follow Policies > Pharmacy > M > Multi-Ingredient Compound Policy

**CLINICAL DOCUMENTATION**

| | |
|---|---|
| **1) List the route of administration for the compound.** | ☐ Oral ☐ Topical ☐ Other: |
| **2) List the member's diagnosis and ICD-10 code(s).** | Diagnosis Description:<br>ICD-10 Code(s): |
| **3) Is a similar, commercially available product available?**<br>• **If yes, indicate why a commercially available product is not acceptable and include the specific medical need for the compound.**<br>• **If yes, indicate why this product.** | ☐ Yes ☐ No<br>_____<br>_____<br>_____<br>_____ |
| **4) Is/Are the active ingredient(s) of the compound FDA approved for the condition being treated in the requested route of administration?** | ☐ Yes ☐ No<br>If no, please attach peer-reviewed medical evidence for support. |

**LIST THE INGREDIENTS FOR THE REQUESTED COMPOUND**

**Note:** Each ingredient used in the compound MUST be listed. Begin the list with covered legend drugs. Please attach an additional form if compound has greater than 10 ingredients.

| Drug Name and/or National Drug Code (NDC) | Dosage Form | Quantity |
|---|---|---|
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**LIST ANY COMMERCIALLY AVAILABLE PRODUCTS ALREADY TRIALED**

Please include product dates of use and reason(s) it cannot be used.

| Trialed Product | Dates of Use *(mm/dd/yy to mm/dd/yy)* | Reason(s) It Cannot Be Used |
|---|---|---|
| | | |
| | | |
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Please list any additional information you would like considered for this review. Attach relevant supporting documentation, including peer-reviewed medical evidence for any active ingredients not FDA approved for the condition or age of member.

_____

_____

Is this a reauthorization? ☐ Yes ☐ No

If this is a reauthorization (you answered "yes" to the question above), do you attest the member has shown benefit from this medication? Attach relevant supporting documentation.

☐ Yes ☐ No

By signing this form, the prescriber attests the above information is accurate and documented in the medical record.

| Prescriber Signature | Date |
|---|---|
| | |