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# Compounded Drugs Prior Authorization Request Form (Page 1 of 4)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.**

This form may be faxed to 844-403-1029.

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | ZIP: | Office Street Address: | | |
| Phone: | | | City: | State: | ZIP: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| | Directions for Use: | |

| Clinical Information (required) | |
|---|---|
| 1. What is the patient's diagnosis for the compound being requested?<br>_____<br>ICD-10 Code(s):_____ | |
| 2. Please list ALL ingredients of the compound being requested:_____<br>_____<br>_____ | |
| 3. Is each active ingredient in the compounded drug FDA-approved for the condition being treated? | ❑ Yes ❑ No |
| 4. Are the therapeutic amounts approved for the condition being treated in the requested route of delivery? | ❑ Yes ❑ No |
| 5. Does the compounded drug include any ingredient that has been withdrawn or removed from the market due to safety reasons? | ❑ Yes ❑ No |
| 6. Has the patient tried and failed therapy or had an intolerance to TWO FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound? | ❑ Yes ❑ No |
| 7. Does the patient have a contraindication to commercially available products? | ❑ Yes ❑ No |
| 8. Are one or no other therapeutic alternatives commercially available? | ❑ Yes ❑ No |
| 9. Is the compound prepared in a strength not commercially available or currently in short supply? | ❑ Yes ❑ No |
| 10. Is the compound prepared in a different dosage form for a patient who is unable to take the commercially available formulation (mixing or reconstituting commercially available products based on the manufacturer's instructions or the product's approved labeling does NOT meet this criteria)? | ❑ Yes ❑ No |
| 11. Does the patient have an allergy or sensitivity to inactive ingredients (e.g., dyes, preservatives, sugars, etc.) that are found in commercially available products? | ❑ Yes ❑ No |
| 12. Is the compounded drug being used for a cosmetic purpose? | ❑ Yes ❑ No |

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| **Diclofenac compounds, also answer the following:** | |
| 1. Does the patient have a diagnosis of one of the following: actinic keratosis, ankylosing spondylitis, inflammatory disorder of the eye, migraine, mild to moderate pain, osteoarthritis, pain due to minor strains, sprains or contusions, pain in the eye, photophobia, primary dysmenorrhea or rheumatoid arthritis? | ❑ Yes ❑ No |
| 2. Will the final dosage form be for oral, topical or ophthalmic use? | ❑ Yes ❑ No |
| 3. Is the final dosage form and strength of the diclofenac ingredient commercially available? | ❑ Yes ❑ No |
| 4. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |
| **Flurbiprofen compounds, also answer the following:** | |
| 1. Does the patient have a diagnosis of one of the following: intraoperative miosis inhibition, osteoarthritis or rheumatoid arthritis? | ❑ Yes ❑ No |
| 2. Will the final dosage form be for oral or ophthalmic use? | ❑ Yes ❑ No |
| 3. Is the final dose commercially available? | ❑ Yes ❑ No |
| 4. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |
| **Fluticasone compounds, also answer the following:** | |
| 1. Does the patient have a diagnosis of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses, including but not limited to: atopic dermatitis, contact dermatitis, eczema, psoriasis? | ❑ Yes ❑ No |
| 2. Is the final dose commercially available? | ❑ Yes ❑ No |
| 3. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |
| 4. Is the compounded product being used for cosmetic purposes (i.e., scar treatment, anti-aging, skin lightening, etc.)? | ❑ Yes ❑ No |
| **Gabapentin compounds, also answer the following:** | |
| 1. Does the patient have one of the following diagnoses: partial seizures, postherpetic neuralgia or restless leg syndrome (RLS)? | ❑ Yes ❑ No |
| 2. Will the final dosage form be for oral use? | ❑ Yes ❑ No |
| 3. Is the requested dose commercially available? | ❑ Yes ❑ No |
| 4. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |

# Compounded Drugs Prior Authorization Request Form (Page 3 of 4)

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|---|---|
| **<u>Ketamine compounds</u>, also answer the following:** | |
| 1. Does the patient require ketamine for conscious sedation prior to a diagnostic or surgical procedure that do not require skeletal muscle relaxation? | ❑ Yes ❑ No |
| 2. Does the patient require ketamine for the induction of anesthesia prior to the administration of other general anesthetic agents? | ❑ Yes ❑ No |
| 3. Does the patient require ketamine as a supplement to low-potency anesthetic agents, such as nitrous oxide? | ❑ Yes ❑ No |
| 4. Will the final dosage form be for injection? | ❑ Yes ❑ No |
| 5. Is the requested dose commercially available? | ❑ Yes ❑ No |
| 6. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |
| 7. Does the requested dose exceed the concentration limit of 100 mg/mL? | ❑ Yes ❑ No |
| **<u>Ketoprofen compounds</u>, also answer the following:** | |
| 1. Does the patient have a diagnosis of one of the following: acute pain, osteoarthritis, primary dysmenorrhea or rheumatoid arthritis? | ❑ Yes ❑ No |
| 2. Will the final dosage form be for oral use? | ❑ Yes ❑ No |
| 3. Is the final dose commercially available? | ❑ Yes ❑ No |
| 4. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |
| **<u>Levocetirizine compounds</u>, also answer the following:** | |
| 1. Does the patient have a diagnosis of one of the following: seasonal or perennial allergic rhinitis or uncomplicated skin manifestations of chronic idiopathic urticaria? | ❑ Yes ❑ No |
| 2. Will the final dosage form be for oral use? | ❑ Yes ❑ No |
| 3. Is the final dose commercially available? | ❑ Yes ❑ No |
| 4. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |
| **<u>Mometasone compounds</u>, also answer the following:** | |
| 1. Does the patient have a diagnosis of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses, including but not limited to: atopic dermatitis, contact dermatitis, eczema, psoriasis? | ❑ Yes ❑ No |
| 2. Is the final dose commercially available? | ❑ Yes ❑ No |
| 3. Has the patient tried and failed therapy or had an intolerance to THREE FDA-approved commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound, unless there is a reason for not using an alternative (e.g., contraindication, two or less similar products commercially available)? | ❑ Yes ❑ No |
| 4. Is the compounded product being used for cosmetic purposes (i.e., scar treatment, anti-aging, skin lightening, etc.)? | ❑ Yes ❑ No |

# Compounded Drugs Prior Authorization Request Form (Page 4 of 4)

*Information on this form is accurate as of this date.*

| **Prescriber's Signature:** | **Date:** |
|---|---|
| | |

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern