



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
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 **CareSource.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: ICD-10 Code(s):
3) Is a similar, commercially available product available? • If yes, indicate why a commercially available product is not acceptable and include the specific medical need for the compound. • If yes, indicate why this product.	Yes No _____ _____ _____ _____
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 If no, please attach peer-reviewed medical evidence for support.

Member Name: _____
Member Date of Birth: _____

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

LIST ANY COMMERCIALY 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

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
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The facsimile and any attached document are confidential and intended for the use of the individual or entity to which it is addressed. If you received this in error, please notify us by telephone immediately at **1-833-230-2112**.