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
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 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.

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 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

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

The facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-877-514-2442**.