COMPOUND MEDICATIONS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the provider may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description**:**	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For ALL Compound Requests:

1. Is the patient currently being treated with the requested compounded agent? ☐ Yes ☐ No

   If yes, when was treatment with the requested compounded agent started? _____

2. Please list all ingredients (attach additional pages if needed):

Product (include strength if applicable)	**Quantity** (include unit of measure)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. Please list all reasons for selecting the requested compound, quantity and dosing schedule over alternatives (e.g., contraindications or allergies to alternatives/preservatives/dyes/fillers, unable to swallow capsules/tablets).

   _____
   _____
   _____
   _____
   _____
   _____

4. Does the patient have a G- or J-tube? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):

5. Does the requested compounded agent have a commercially available dosage form (e.g., tablet) that the patient cannot take (e.g., physically unable to swallow, allergy to preservative)? ☐ Yes ☐ No

6. Does the requested compounded agent contain a drug/drug class/medical condition that is on the list of drugs/drug classes/medical conditions which are excluded from coverage under the pharmacy benefit? This MAY include the following:
   A. Erectile dysfunction or enhancing libido
   B. To promote weight loss
   C. Cosmetic purposes (e.g., wrinkles, age spots, skin lightening)
   D. Hair growth
   E. To promote fertility

   ☐ Yes ☐ No

7. Is the requested compounded agent being compounded to meet specific patient need for which an FDA approved product is not available? For example:
   a. Patient is physically unable to swallow (i.e., G- or J- tube)
   b. Patient is sensitive to dyes, preservatives, or fillers
   c. Patient has a medical need for a different dosage, form or strength than is commercially available

   ☐ Yes ☐ No

8. Does the requested compounded agent have an identical (i.e., same route of administration, dose form and strength) commercially available FDA-labeled agent? ☐ Yes ☐ No
   If yes, is the commercially available agent the subject of a drug shortage making it unavailable for dispensing? ☐ Yes ☐ No
   If no, does the patient have allergies to the commercially prepared products? ☐ Yes ☐ No
   If no, does the patient have a documented failure or intolerance to the commercially available product? ☐ Yes ☐ No
   If yes, will the other agent(s) be discontinued prior to starting this requested compound? ☐ Yes ☐ No
   If yes to any of the above please explain: _____
   _____

9. Please list any other medications the patient will use in combination with the requested medication for the treatment of this diagnosis. _____
   _____
   _____

10. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis**. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, Minnesota 55121

TOLL FREE
Fax: 877.243.6930 Phone: 855.457.0407