

# 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 prior authorization consideration. For formulary information and to download additional forms, please visit <https://www.bcbstx.com/provider/medicaid/pharmacy/star-kids-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: |
| <b>For ALL Compound Requests:</b>  |                     |
| 1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If yes</b> , when was treatment with the requested medication started? _____   |                     |
| 2. Please list all active prescription ingredients (attach additional pages if needed):<br><b>Product</b> (include strength if applicable) <b>Quantity</b> (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 requested compounded agent have an identical (i.e., same route of administration, dosage form and strength) commercially available FDA-labeled agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If yes</b> , is the commercially available agent the subject of a drug shortage making it unavailable for dispensing? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If no</b> , does the patient have allergies to the commercially prepared products? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If no</b> , does the patient have a documented failure or intolerance to the commercially available product? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br><b>If yes</b> , will the other agent(s) be discontinued prior to starting this requested compound? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes to any of the above please explain: _____ |                     |
| _____  |                     |

**Please continue to the next page.**

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

5. Is the requested compounded agent being compounded to meet specific patient need for which an FDA labeled product is not available? For example:

- Patient is physically unable to swallow (i.e., G- or J- tube)
- Patient is sensitive to dyes, preservatives, or fillers
- Patient has a medical need for a different dosage, form or strength than is commercially available

.....  Yes  No

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

7. 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): _____ |

**For compounded vancomycin suspension:**

8. Does the patient have Staphylococcal enterocolitis infection? .....  Yes  No

9. Does the patient have Clostridium difficile-associated diarrhea caused by Staphylococcal enterocolitis? .....  Yes  No

**If yes**, has the patient tried metronidazole for this infection? .....  Yes  No

**If no metronidazole trial**, please provide reason (if applicable)? \_\_\_\_\_

**For compounded tobramycin, gentamicin, or colistin inhalation solution:**

10. Is the requested agent prescribed for cystic fibrosis or lung infection caused by Pseudomonas aeruginosa? .....  Yes  No

11. Is the patient pregnant? .....  Yes  No

12. Is the requested agent being used for inhalation only? .....  Yes  No

13. Is the patient currently using other inhaled antibiotics/anti-infective agents, including alternating treatment schedules? .....  Yes  No

**If yes**, will the other agent(s) be discontinued prior to starting this requested compound? .....  Yes  No

14. For tobramycin inhalation, is the patient colonized with Burkholderia cepacia? .....  Yes  No

15. Does the patient have an FEV1 < 90% of predicted? .....  Yes  No

**For compounded hydroxyprogesterone injection:**

16. Is the patient a pregnant female? .....  Yes  No

17. How many weeks gestation is the patient? \_\_\_\_\_ weeks and \_\_\_\_\_ days

18. Does the patient have a singleton pregnancy (e.g., not twins, triplets)? .....  Yes  No

19. Has the patient had at least one spontaneous singleton preterm pregnancy in the past (defined as before 37 weeks' gestation)? .....  Yes  No

20. Currently, does the patient have any of the following? *Check all apply.*

- An interval of less than 6 months between pregnancies
- Conception through in vitro fertilization
- Problems with uterus, cervix, or placenta
- Smoke cigarettes, drink alcohol, or use illicit drugs

**For compounded bulk powder progesterone:**

21. Is the requested agent being used to promote fertility? .....  Yes  No

---

**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.*

|  |   |
|--|---|
| <p><b>Please fax or mail this form to:</b><br/>         Prime Therapeutics LLC, Clinical Review Department<br/>         2900 Ames Crossing Road Suite 200<br/>         Eagan, Minnesota 55121</p> <p><b>TOLL FREE</b></p> <p><b>Fax: 877.243.6930      Phone: 855.457.1200</b></p> | <p><b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 866.202.3474 and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p> |
|--|---|