

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 treated with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , when was treatment with the requested medication 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to page 2.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
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For compounded vancomycin suspension:

5. Does the patient have Staphylococcal enterocolitis infection? Yes No
6. 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:

7. Is the requested agent prescribed for cystic fibrosis or lung infection caused by Pseudomonas aeruginosa? Yes No
8. Is the patient pregnant? Yes No
9. Is the requested agent being used for inhalation only? Yes No
10. 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
11. For tobramycin inhalation, is the patient colonized with Burkholderia cepacia? Yes No
12. Does the patient have an FEV1 < 90% of predicted? Yes No

For compounded hydroxyprogesterone injection:

13. Is the patient a pregnant female?..... Yes No
14. How many weeks gestation is the patient? _____ weeks and _____ days
15. Does the patient have a singleton pregnancy (e.g., not twins, triplets)? Yes No
16. Has the patient had at least one spontaneous singleton preterm pregnancy in the past (defined as before 37 weeks' gestation)? Yes No
17. 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:

18. 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.

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

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.0407

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