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:

For ALL Compound Requests:

1. Is the patient currently treated with the requested medication?..... ☐ Yes ☐ No

   If no, 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?..... ☐ Yes ☐ No

Please continue to page 2.

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

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:

17. 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: 855.457.1200