

COMPOUNDED PRESCRIPTIONS PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Compounded Prescriptions, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Compounded Prescriptions (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

<u>PRIOR AUTHORIZATION REQUEST INFORMATION</u>		<u>PRESCRIBER INFORMATION</u>	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
<u>RECIPIENT INFORMATION</u>		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:
<u>CLINICAL INFORMATION</u>			
Name & strength of compounded product requested:			
Directions:		Quantity:	Refills:
Diagnosis:		Diagnosis code (required):	
List ALL ingredients (active and inactive) to be included in the compounded product, including amount/strength of each ingredient.			
<i>Ingredient name</i>		<i>Amount/quantity</i>	<i>Final strength/concentration</i>
1.			
2.			
3.			
4.			
5.			
Complete appropriate section for initial requests or renewal requests.			
<u>Initial Requests</u>			
1. What is the clinical rationale or reason for using a compounded product instead of an FDA-approved product?			
2. Is the use of the compounded product for the Recipient's condition supported by peer-reviewed medical literature?			<input type="checkbox"/> Yes – <i>submit documentation of medical literature supporting the use of the compound</i> <input type="checkbox"/> No
<u>Renewal Requests</u>			
1. Has the Recipient experienced clinical improvement for the condition being treated with the compounded product?			<input type="checkbox"/> Yes – <i>submit documentation supporting improvement & continued use</i> <input type="checkbox"/> No
PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION			
Prescriber Signature:			Date:

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