



COMPOUND PRIOR AUTHORIZATION FORM

FAX NUMBER: 318-214-4190

FOR **URGENT REQUESTS**, please call 800-710-9341.

Regular Hours: M-F 7:00am-5:00pm (Central Time Zone)



PLEASE MARK ✓ FOR

EXPEDITED REVIEW

DATE OF REQUEST		OFFICE CONTACT PERSON		OFFICE PHONE NUMBER	
Date:		Name:		Phone Number:	
MEMBER INFORMATION (REQUIRED)			PROVIDER INFORMATION (REQUIRED)		
Name:			Provider Name:		
DOB:		NPI #:		Specialty:	
Rx Group #:		Office Phone #:		Is FAX secured? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Southern Scripts ID:		Office Fax #:			
Phone #:		Office Address (Street, City, State, Zip Code):			
PHARMACY INFORMATION					
Pharmacy Name:		Prescription #:		Claim #:	
Pharmacy Phone #:			Pharmacy Fax #:		
MEDICATION INFORMATION (REQUIRED)					
** MUST BE COMPLETED. INCOMPLETE FORMS WILL BE DENIED! **					
Compounds are not approved for topical formulations containing flurbiprofen, gabapentin and ketamine due to lack of clinical efficacy and safety data, and/or standardized dosages and formulations.					
Member Diagnosis:		ICD-10 Code:	Anticipated Length of Therapy:		Route of Administration:
COMPOUND REQUESTED	COMPOUND INGREDIENT NAME	NDC	QTY	UNIT (e.g., mL)	
Name: _____					
Please List All Ingredients. Attach an additional sheet if more space is needed. Note: If you are changing the compound formulation, send the new order to the pharmacy					
Are all the active ingredients in this compound FDA Approved for the condition being treated? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE ATTACH OR REFERENCE PEER-REVIEWED MEDICAL EVIDENCE THAT THIS TREATMENT IS SAFE AND EFFECTIVE					
Does the patient have evidence of failure, intolerance, contraindication, or inadequate response to conventional therapies for this condition? <input type="checkbox"/> YES <input type="checkbox"/> NO					
IF YES, PLEASE ATTACH DETAIL INFORMATION (name of medications, doses, and dates of trial). IF NO, please explain.					
**Other pertinent information to support this medication is medically necessary, please attach additional information such as progress notes if needed. **					
I certify that, to the best of my knowledge, the information above is accurate.					
Prescriber's Signature: _____			Date: _____		
SOUTHERN SCRIPTS ONLY:					