southernscripts

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? ☐ YES ☐ 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? ☐ YES ☐ 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?
☐ YES ☐ 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: