Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Compounded Drug Products

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Compounded Drug Products .

Drug Name (select from list of drugs shown)

Other, Please specify

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for a topical compound or a topical compound kit (e.g. cream, gel, lotion, ointment)?	Y N
[If yes, then no further questions.]	
2. Is this request for ANY of the following: A) injectable or intravenous use, B) pyrimethamine?	Y N
[Note: Examples of products for injectable or intravenous use are anti-infectives/antibiotics, heparin, total parenteral nutrition (TPN), hydroxyprogesterone, leuprolide acetate for infertility in a patient unable to utilize the FDA-approved commercially available product (1mg per 0.2mL kit)]	
[If yes, then no further questions.]	

3. Is the compound intended for anti-aging or cosmetic use, OR is a compound kit, OR contains any of the following ingredients: A) bulk powder, B) dietary supplement?	Y N
[Note: Examples of bulk powders are cholestyramine, cidofovir, collagenase, fentanyl, fluticasone, heparin, ketamine, ketorolac, mometasone, oxycodone, sertraline; Examples of dietary supplements are cholesterol, coenzyme Q10, hydroxocobalamin, lipoic acid, resveratrol, tetrahydrobiopterin, ubiquinol]	
[If yes, then no further questions.]	
4. Is this request for a hormone therapy compound for menopause OR for androgen decline due to aging, (e.g., testosterone, estrogen, progestin, bioidentical hormone)?	Y N
[If yes, then no further questions.]	
5. Are each of the active ingredients in the compound FDA-approved drugs?	Y N
[Note: Examples of products that typically do not get FDA approval include bulk ingredients, dietary supplements, vitamin and mineral products, botanical or herbal products, amino acid products, enzyme supplements.]	
6. Are each of the active ingredients in the compound FDA-approved for the indication for which the compound is being prescribed?	Y N
7. Is the compound route of administration the same as the FDA-approved route of administration (ROA) for each active ingredient?	Y N
[Note: Examples of ROAs include mucosal, oral, parenteral (by injection), inhalation, topical/dermal]	
8. Is the dosage or concentration of each active ingredient in the compound equal to or below the FDA-approved dosage or concentration?	Y N
9. Is there a current supply shortage of the commercially manufactured product?	Y N
[If yes, then skip to question 13.]	
10. Does the patient have a medical need for a dosage form or dosage strength that is not available commercially or manufactured?	Y N
[If yes, then skip to question 13.]	
11. Has the patient had an intolerance or contraindication to the commercially manufactured product (e.g., allergen, adverse effects to inactive ingredients)?	Y N
[If yes, then skip to question 13.]	
12. Has the commercial product been discontinued by the pharmaceutical manufacturer for reasons other than lack of safety or effectiveness?	Y N
13. Does the patient need more than 1 fill per month of the compounded drug (necessity may include continuation of antibiotic therapy, stability is less than a month, dose adjustment)?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date