COVERAGE DETERMINATION REQUEST FORM

EOC ID:

Compound Prior Authorization

Phone: 844-838-1522 Fax back to: 866-414-3453

MedImpact manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

****Please note that MedImpact will process the request as written, including drug name, with no substitution.***

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Therapy is:

☐ New ☐ Continuing therapy

Q2. If the request is for CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Provide diagnosis or diagnosis code:

Q4. Please list all components of the requested compound:

Q5. Please provide any supporting clinical statements such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information to support an authorization request (if needed):

Q6. Does the requested compounded product contains at least ONE prescription ingredient?

☐ Yes ☐ No

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Q7. Is the requested compounded product a copy of a commercially available FDA-approved product?

☐ Yes ☐ No

Q8. Is the dosage form being compounded due to the patient being unable to use the commercially available product?

☐ Yes ☐ No

Q9. Is the patient unable to use a commercially available product due to a hypersensitivity or allergy to any of the components (i.e. dyes, preservatives, fragrances, gluten)?

☐ Yes ☐ No

Q10. Is there is a commercially available product shortage or discontinuation by the manufacturer?

☐ Yes ☐ No

Q11. Does the requested compounded product contains bulk powders?

☐ Yes ☐ No

Q12. Please specify if the unique dosage form is considered standard of care based on credible scientific literature defined as one of the following (select all that apply):

☐ Peer reviewed literature indexed in Medline

☐ CMS recognized pharmacy compendia (e.g. NCCN, DrugDex, and AHFS DI)

☐ Published clinical practice guidelines developed by multidisciplinary experts and clinicians affected by the guidelines (e.g. American Medical Association, Infectious Disease Society of America)

☐ Other

☐ None of the above

Q13. If answer is OTHER, please specify below:

Q14. For renewal, has the patient had disease stabilization or improvement with the use of this compounded product?

☐ Yes ☐ No

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Prescriber Signature ____________________ Date ____________________

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