Prior Authorization Request

EOC: COMPOUND

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Fill out electronically, or print using blue or black ink. If you have questions or need additional forms, visit ServeYouRx.com or call 800-759-3203.

Fax completed form to: 800-480-4840, Attn: Authorizations **Note:** Blank fields or illegible responses may delay the review process.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Member ID #: _____ Group #: _____

Permanent Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone #: _____ ☐ Mobile ☐ Work ☐ Home

Secondary Phone #: _____ ☐ Mobile ☐ Work ☐ Home

PRESCRIBER INFORMATION

Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ ZIP: _____

NPI: _____ State License ID: _____

Office Contact: _____ Fax: _____ Phone: _____

REQUESTED MEDICATION

Drug Name: _____ Strength: _____ Frequency: _____

Directions: _____

Expected Duration of Therapy: _____ If this is a continuation of therapy, provide start date: _____

☐ **Pertinent medical history or information for this patient is attached that may support approval**

☐ **Urgent review requested**

REQUIRED INFORMATION

1 Please list all ingredients (name/strength):

2 Indicate the final form of the compound (e.g., cream, suppository, suspension):_____

3 Diagnosis for use: _____

4 Duration of therapy: _____

5 Are products to treat the patient's condition commercially available? ☐ Yes ☐ No

6 Does the patient have a history of failure, contraindication, or intolerance to commercially available products? (please provide chart note documentation) ☐ Yes ☐ No

7 List which drugs have been tried and failed:

8 Are the requested drug components FDA-approved for the condition being treated? ☐ Yes ☐ No

9 If the compound requested is for an off-label indication, please provide two examples of peer reviewed literature that demonstrate the safety and efficacy of the combination of ingredients used for the given indication for use.

1. _____
2. _____

10 Additional Comments:

11 Prescriber Signature: _____

Today's Date (month/day/year): _____

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.