

# 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](https://www.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.

<b>PATIENT INFORMATION</b>	
Last Name: _____	First Name: _____ MI: _____
Date of Birth: _____	Member ID #: _____ Group #: _____
Permanent Address: _____	City: _____ State: _____ ZIP: _____
Primary Phone #: _____	Secondary Phone #: _____
<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

<b>PRESCRIBER INFORMATION</b>	
Name: _____	Specialty: _____
Address: _____	City: _____ State: _____ ZIP: _____
NPI: _____	State License ID: _____
Office Contact: _____	Fax: _____ Phone: _____

<b>REQUESTED MEDICATION</b>	
Drug Name: _____	Strength: _____ Frequency: _____
Directions: _____	
Expected Duration of Therapy: _____ If this is a continuation of therapy, provide start date: _____	
<input type="checkbox"/> <b>Pertinent medical history or information for this patient is attached that may support approval</b>	
<input type="checkbox"/> <b>Urgent review requested</b>	

<b>REQUIRED INFORMATION</b>	
<b>1</b> Please list all ingredients (name/strength): _____	<b>8</b> Are the requested drug components FDA-approved for the condition being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>2</b> Indicate the final form of the compound (e.g., cream, suppository, suspension): _____	<b>9</b> 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. _____
<b>3</b> Diagnosis for use: _____	<b>10</b> Additional Comments: _____
<b>4</b> Duration of therapy: _____	<b>11</b> Prescriber Signature: _____ Today's Date (month/day/year): _____
<b>5</b> Are products to treat the patient's condition commercially available? <input type="checkbox"/> Yes <input type="checkbox"/> No	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.
<b>6</b> Does the patient have a history of failure, contraindication, or intolerance to commercially available products? (please provide chart note documentation) <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>7</b> List which drugs have been tried and failed: _____	

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