





COMPOUND > \$300 PRIOR AUTHORIZATION REQUEST FORM

Medicaid: 1-866-399-0928 (fax: 1-833-546-1507) **Ambetter**: 1-866-399-0928 (fax: 1-800-977-4170)

Children's Medical Services Health Plan: 1-833-705-1351 (fax: 1-888-865-6531)

Name: Specialty: NPI or DEA Number: Group or Hospital: Address: City, State, Zip: Phone: Fax: Office Contact Name: compounded medication request per form) Dosage/Strength/ nstructions Rx # (if claim has been submitted) Therapy Start Date:
NPI or DEA Number: Group or Hospital: Address: City, State, Zip: Phone: Fax: Office Contact Name: compounded medication request per form) Dosage/Strength/ nstructions Rx # (if claim has been submitted) Therapy Start Date:
NPI or DEA Number: Group or Hospital: Address: City, State, Zip: Phone: Fax: Office Contact Name: compounded medication request per form) Dosage/Strength/ nstructions Rx # (if claim has been submitted) Therapy Start Date:
Address: City, State, Zip: Phone: Fax: Office Contact Name: compounded medication request per form) Cosage/Strength/ Instructions Rx # (if claim has been submitted) Therapy Start Date:
City, State, Zip: Phone: =ax: Office Contact Name: compounded medication request per form) Cosage/Strength/ nstructions Rx # (if claim has been submitted) Therapy Start Date:
Phone: Fax: Office Contact Name: compounded medication request per form) Dosage/Strength/ nstructions Rx # (if claim has been submitted) Therapy Start Date:
Compounded medication request per form) Dosage/Strength/ Instructions Rx # (if claim has been submitted) Therapy Start Date:
Compounded medication request per form) Dosage/Strength/ nstructions Rx # (if claim has been submitted) Therapy Start Date:
Compounded medication request per form) Dosage/Strength/ Instructions Rx # (if claim has been submitted) Therapy Start Date:
Dosage/Strength/ nstructions Rx # (if claim has been submitted) Therapy Start Date:
Rx # (if claim has been submitted) Therapy Start Date:
Therapy Start Date:
evant to this request)
CD10:
NOTE: Include diagnostic clinicals (labs, radiology, etc.).
ORY (for this diagnosis)
long? No; if no, skip items B&C, go to D
s; if yes, go to item C. No; if no, skip item C, go to D.
ASED: DECREASED: Remained the
Dates of Therapy Reason for Discontinuation
- Zuisc Si Tilolupy
PERTINENT CLINICAL INFORMATION uired for all PA's. Attach additional sheets if more space is needed.
S

Prescriber Signature – Substitution Permitted:	
X	Date: