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)

TODAY'S DATE: _____

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		Phone:	
Alternate Phone:		Fax:	
Medication Allergies:		Office Contact Name:	

IV. MEDICATION REQUESTED (only ONE compounded medication request per form)			
Compound Drug Information		Dosage/Strength/ instructions	
		Rx # (if claim has been submitted)	
Refills/Length of Tx:		Therapy Start Date:	

V. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD10:	
Date of Diagnosis:		*NOTE: Include diagnostic clinicals (labs, radiology, etc.).*	

VII. MEDICATION HISTORY (for this diagnosis)

A. Is the member currently on this medication? ☐Yes; if yes, how long? _____ ☐No; if no, skip items B&C, go to D.

B. Is this a request for continuation of a previous approval? ☐Yes; if yes, go to item C. ☐No; if no, skip item C, go to D.

C. Has the strength, dosage, or quantity required per day: ☐INCREASED: _____ ☐DECREASED: _____ ☐Remained the same

D. Indicate any PREVIOUS medications treatment/outcomes below. *NOTE: Confirmation will be made using claims history.*

	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			
4			

VIII. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION

NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.

Prescriber Signature – Substitution Permitted:

X_____ Date: _____

Please access SunshineHealth.com or contact provider services for a current listing of preferred products