

Compounds and Bulk Powders - Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

- What is the compound dosage form being requested?

- Capsule
 Oral Liquid
 Topical Cream/Ointment
 Suppository
 Other, specify: _____

Compound Information

(All fields should be completed to avoid denial or cancelation of your request)

Name of each ingredient in compound (include all drugs and fillers)	NDC of Ingredient	Amount to be dispensed
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the drug component no longer available commercially because it was withdrawn for safety reasons?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is a unique vehicle required for topically administered compounds?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is a unique dosage form required for a commercially available product due to patient's age, weight, or inability to take a solid dosage form? <i>If yes, list unique dosage form reason:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is a unique formulation required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product? <i>If yes, list inactive ingredient and allergy or intolerance:</i>

REQUESTED COMPOUND CONTAINS TOPICAL FLUTICASONE

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the topical fluticasone intended to treat a dermatologic condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a contraindication to all commercially available topical fluticasone formulations? <i>(If yes, complete Section D above)</i>

Provider Signature: _____ **Date:** _____

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