OHIO DEPARTMENT OF MEDICAID

# PRIOR AUTHORIZATION COMPOUND MEDICATIONS

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|---|---|---|---|---|---|
| Request Date | | | | Review Type Requested ☑ Standard ☐ Urgent | |
| Individual Full Name | | | | Prescriber's Full Name | |
| Individual Date of Birth | | | | Prescriber's NPI Number | |
| Individual Medicaid ID Number | | | | Prescriber's Address | |
| Age | Height | Weight | Sex | Prescriber's Phone Number | Prescriber's Fax Number |
| **(If Known)** Pharmacy Name | | | | Pharmacy's Phone Number | |
| Compound Name | | | | Total Quantity | Days' Supply |
| Sig: | | | | | |

List the NDC, name, dosage form, and quantity (QTY) of each ingredient. Each ingredient used in the compound MUST be listed. Begin the list with the covered legend drugs. Please attach an additional form if compound has greater than 10 ingredients.

| NDC | DRUG NAME | DOSAGE FORM | QUANTITY |
|---|---|---|---|
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**Clinical Criteria**

Please provide the diagnosis the compound is intended to treat

Please provide the route of administration for the final form of the compound

☐ Oral ☐ Topical ☐ Other *(Please specify)*

Is the active ingredient(s) of the compound FDA-approved for the condition being treated (i.e. diagnosis) in the requested route of administration?

☐ Yes ☐ No - **TO AVOID DELAYS PLEASE ENSURE YOUR REQUEST INCLUDES PEER-REVIEWED MEDICAL EVIDENCE TO SUPPORT COMPOUND USE**

**Fax To: Ohio Department of Medicaid**
**Fax: (800) 396 – 4111 PA Helpdesk: (877) 518 – 1546**
**Hours: Monday – Friday 8:00 am – 8:00 pm EST**

Please address what commercially available products have been trialed prior to the use of this compound OR address why the compound is necessary over commercially available products for the indicated diagnosis *(may provide progress notes that address this in place of written response)*

☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

_____ _____

Prescriber's Signature *(or staff of prescriber)* Date

_____

IF a staff member is attesting, please print your name

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