

OHIO DEPARTMENT OF MEDICAID
Prior Authorization Compound Medications

Request Date	
Individual	Prescriber
Name	Name
Medicaid ID Number	NPI
Date of Birth	Phone Number
Address	Fax Number

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

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 <i>(Please specify)</i>		
Is the active ingredient (s) of the compound FDA-approved for the condition being treated (i.e. diagnosis) in the requested route of administration? <input type="checkbox"/> Yes <input type="checkbox"/> No - TO AVOID DELAYS PLEASE ENSURE YOUR REQUEST INCLUDES COPIES OF 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)*

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I attest that I am a member of the prescriber's staff in accordance with OAC 5160-9-03.

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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