Compound medication prior authorization request form

UnitedHealthcare Community Plan of Texas

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:	Date of birth (DOB):	Allergies:
Primary insurance information (if any):		

Is the requested medication: ☐ New OR ☐ Continuation of therapy?

If continuation, list start date:

Is this patient currently hospitalized? ☐ Yes ☐ No

If recently discharged, list discharge date:

Section B: Provider information		
First name:	Last name:	☐ M.D.: ☐ D.O.: ☐ Other:
Address:		
City:	State:	ZIP code:
Phone:	Fax:	National Provider Identifier (NPI) number:
Specialty:	Office contact name/Fax attention to:	

Section C: Medical information		
Medication:	Strength:	
Directions for use:	Quantity:	
Diagnosis (please be specific and provide as much information as possible):	ICD-10 code:	

Is this member pregnant? ☐ Yes ☐ No If yes, what is this member's due date?

Member first name:	Member last name:	Member DOB:

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 prescription drug list (PDL) at **UHCprovider.com** for a list of preferred alternatives.

Clinical and drug-specific information

What is the compound dosage form being requested?

☐ Capsule ☐ Oral liquid ☐ Topical cream/ointment ☐ Suppository

Other, specify:

Member first name:	Member last name:	Member DOB:

Compound information (Complete all fields to avoid denial or cancellation of your request)		
Name of each ingredient in compound (include all drugs and fillers)	**National drug code (NDC) of ingredient**	**Amount to be dispensed**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

All requests		
☐ Yes	☐ No	Is the drug or drug component no longer available commercially because it was withdrawn for safety reasons?
☐ Yes	☐ No	Is a unique vehicle required for topically administered compounds?
☐ Yes	☐ No	Is a unique dosage form required for a commercially available product due to patient's specific medical needs? If yes, list medical needs:
☐ Yes	☐ 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? If yes, list reason:
☐ Yes	☐ No	Is the drug or drug component currently on backorder or in short supply?
Requested compound contains topical fluticasone		
☐ Yes	☐ No	Is the topical fluticasone intended to treat a dermatologic condition?
☐ Yes	☐ No	Does the patient have a contraindication to all commercially available topical fluticasone formulations? (If yes, complete Section D above.)

Provider signature:	Date:

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