



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:		<i>NOTE: Include diagnostic clinicals (labs, radiology, etc.).</i>	
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. <i>NOTE: Confirmation will be made using claims history.</i>			
Drug Name, Strength, and Dosage		Dates of Therapy	Reason for Discontinuation
1			
2			
3			
4			
VIII. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION			
<i>NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.</i>			

Prescriber Signature – Substitution Permitted:

X _____ Date: _____

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

SH_4066