UnitedHealthcare Community Plan

Compounds Medications - Texas
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: □ 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.
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? □ Yes □ 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

UnitedHealthcare Community Plan

Compounds Medications - Texas
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

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	
□ Yes □ No	**Is the drug or drug component no longer available commercially because it was withdrawn for safety reasons?**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 is 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: _____