pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

COMPOUNDED PRESCRIPTIONS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Compounded Prescriptions** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Name & strength of compounded product requested:		
Directions:	Total quantity:	Refills:
Diagnosis:	Diagnosis code (*required*):	

List ALL ingredients (active and inactive) to be included in the compounded product, including amount/strength of each ingredient.

Ingredient name	*Amount/quantity*	*Final strength/concentration*

Complete appropriate section for initial requests or renewal requests.

INITIAL requests	
What is the clinical rationale or reason for using a compounded product instead of an FDA-approved product?	
Is the use of the compounded product for the beneficiary's condition supported by peer-reviewed medical literature?	☐Yes – *Submit documentation of medical literature supporting the use of the compound.* ☐No
RENEWAL requests	
Has the beneficiary experienced clinical improvement for the condition being treated with the compounded product?	☐Yes – *Submit documentation supporting improvement & continued use.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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