GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Multi-Ingredient Compound Drug Prior Authorization Request Form (Page 1 of 2)

Compound Request- The form should be completed in its entirety to ensure proper processing. An attached prescription is necessary to process the request. Additional pertinent information may also be submitted.

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Member diagnosis: _____

ICD-10 Code(s): _____

Compound requested:

If applicable, indicate why a commercially available product is not acceptable and include the specific medical need for the compound; list previous failed therapies if known.

Ingredients:

Ingredient Name	11 Digit NDC Number	Quantity	Unit (e.g., mls)

Pharmacy information:

Pharmacy Name:	**Pharmacy NPI #:**
Pharmacy Phone #:	**Pharmacy Fax #:**
Pharmacist Signature & Date:	

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Multi-Ingredient Compound Drug Prior Authorization Request Form (Page 2 of 2)

*****For compound requests containing Proton Pump Inhibitors (PPI) ONLY, please complete below (omeprazole and pantoprazole compound requests do not require PA). *****

Select the diagnosis below:

- ❑ Barrett's esophagus
- ❑ Duodenal ulcer/Gastric ulcer/Peptic Ulcer Disease (PUD)
- ❑ Erosive esophagitis
- ❑ Gastroesophageal reflux disease (GERD)
  - ❑ without complications
  - ❑ with complications- please specify: _____
- ❑ H. Pylori
- ❑ Prophylactic therapy following gastric bypass surgery
- ❑ Recent discharge from hospital (within the last 60 days) for an upper GI bleed, hemorrhage, perforation, or obstruction and already started in the hospital on PPI therapy
- ❑ Zollinger Ellison (ZE) Syndrome
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select if the member has any of the following complicated disease states:

❑ Anticoagulant therapy	❑ Cystic Fibrosis	❑ Laryngopharyngeal reflux
❑ Cancer	❑ Dysphagia	❑ Multiple endocrine adenomas
❑ Cerebral Palsy	❑ ESRD	❑ Neurological/neuromotor impairment
❑ Chronic oral corticosteroid/NSAID use	❑ Esophageal varices	❑ Pancreatitis
❑ Chronic pulmonary disease	❑ G-tube (gastric tube)	❑ Sleep apnea
❑ Congenital esophageal abnormality	❑ Gastritis	❑ Systemic mastocytosis
❑ COPD	❑ Hematemesis	❑ Theophylline therapy
❑ Crohn's	❑ Hiatal hernia	❑ Post-transplant

Medication history:

Has the member completed a 30 days' supply for omeprazole in the past 6 months? ❑ **Yes** ❑ **No**

Has the member completed a 30 days' supply for pantoprazole in the past 6 months? ❑ **Yes** ❑ **No**

Is the requested medication being administered in a G-tube (gastric tube)? ❑ **Yes** ❑ **No**

If **yes**, has the member tried and failed a 30-day trial of Prevacid Solutab? ❑ **Yes** ❑ **No**

For Aciphex Sprinkle, prescription Nexium (capsules or granules) & prescription esomeprazole requests, also answer the following:

Is the member unable to swallow solid dosage forms (e.g., tablets, capsules)? ❑ **Yes** ❑ **No**

Has the member tried and failed omeprazole? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-888-491-9742.