

TRICARE Prior Authorization Request Form for
Compounded Medications



6084

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TPharmPA@express-scripts.com
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Step 1 Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

Step 2 * * Please note that only 1 form is required for each compounded product.

Document the active ingredient(s) in this compound:

Step 3 Please complete the clinical assessment:

1.	What is the diagnosis?	
2.	What is the route of administration?	
3.	What are the directions for use?	
4.	What is the proposed duration of therapy?	
5.	What is the reason that a compounded product is being prescribed rather than a commercially-available product?	
6.	Has the patient tried commercially available products for the diagnosis provided?	<input type="checkbox"/> Yes Proceed to 7 <input type="checkbox"/> No SKIP to question 8
7.	Please provide all products tried and the results of therapy:	

continue to next page

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8. Is there a current national drug shortage of an otherwise commercially-available product that could be used in this patient?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No Proceed to question 9
9. Does the prescribed route of administration of the compound match the FDA-approved route of administration of the active ingredient(s) in the compound?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No Proceed to question 10
10. Is there any other information you would like to provide to support this request? If "Yes", please document below:	<input type="checkbox"/> Yes Proceed to 11	<input type="checkbox"/> No Proceed to 11

11. Please submit evidence with this form to support that: **(1)** each ingredient is lawfully marketed in the U.S. and is proven safe and effective (that is, [i] approved for commercial marketing by the FDA, [ii] proven safe and effective under TRICARE standards, or [iii] meets the requirements for being widely recognized in the U.S. as being safe and effective), **(2)** the compound is clinically appropriate for the patient, and, **(3)** an FDA-approved commercially-available product is not appropriate because the patient requires a unique dosage form or concentration, or for other clinical reason.

Step 4 I certify the above is true to the best of my knowledge. Please sign and date:

4

 Prescriber Signature

 Date

[25 September 2015]