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 | • The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477**<br>• 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** |

Prior authorization will expire after the proposed duration or after one year, whichever is less.

**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? | ☐ Yes Proceed to 7 | ☐ No **SKIP** to question **8** |
| **7.** Please provide all products tried and the results of therapy: | | |

***continue to next page***

TRICARE Prior Authorization Request Form for
# Compounded Medications

| | | |
|---|---|---|
| **8.** Is there a current national drug shortage of an otherwise commercially-available product that could be used in this patient? | ☐ Yes<br>Proceed to question 9 | ☐ No<br>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? | ☐ Yes<br>Proceed to question 10 | ☐ No<br>Proceed to question 10 |
| **10.** Is there any other information you would like to provide to support this request? If "Yes", please document below: | ☐ Yes<br>Proceed to 11 | ☐ No<br>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:

_____ _____
Prescriber Signature Date