PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Virginia Premier Compound Prior Authorization

Phone:
Medallion 855-872-0005 **Fax back to: 866-754-9616**
VPEPLUS 844-838-0711

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is request for initial or continuing therapy?

☐ Initial ☐ Continuing

Q2. IF CONTINUING THERAPY, then please provide the start date (MM/YY). If the requested medication was approved by a previous Health Plan, please submit documentation of the previous approval.

Q3. Please provide the patient's diagnosis below:

Q4. If a commercial product is not available, then was it withdrawn for safety reasons?

☐ Yes ☐ No

Q5. If a commercial product is available, then is a unique dosage form required due to patient's age, weight, or inability to take a solid dosage form?

☐ Yes ☐ No

Q6. Does the requested compounded medication contain 5 active ingredients?

☐ Yes ☐ No

Q7. IF YES, then has the patient had a 60-day trial and failure of a compound with 4 active ingredients?

☐ Yes ☐ No or Unknown

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Q8. Does the requested compounded medication contain 6 active ingredients?

☐ Yes ☐ No

Q9. IF YES, then has the patient had a 60-day trial and failure of a compound with 5 active ingredients?

☐ Yes ☐ No or Unknown

Q10. Please provide the name(s) of the Active Ingredient(s):

Q11. Please provide the name(s) of the Vehicle(s):

Q12. Does the requested medication contain topical fluticasone?

☐ Yes ☐ No or Unknown

Q13. IF YES, then does the patient have a contraindication to all commercially available topical fluticasone formulations?

☐ Yes ☐ No or Unknown

Q14. Does the requested medication contain gabapentin?

☐ Yes ☐ No or Unknown

Q15. IF YES, then is gabapentin the only active ingredient?

☐ Yes ☐ No or Unknown

Q16. IF YES, then is the gabapentin compound being administered topically?

☐ Yes ☐ No or Unknown

Q17. IF YES, then does the patient have a diagnosis of vulvodynia?

☐ Yes ☐ No or Unknown

Q18. IF YES, then has the patient previously tried two oral or topical agents for the treatment of vulvodynia?

☐ Yes ☐ No or Unknown

Q19. Does the requested compounded medication require a unique vehicle?

☐ Yes ☐ No or Unknown

Q20. IF YES, then is the requested compounded medication being administered topically?

☐ Yes ☐ No or Unknown

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Q21. Does the requested medication contain flurbiprofen?

☐ Yes ☐ No or Unknown

Q22. IF YES, then is flurbiprofen being administered for topical ophthalmic use?

☐ Yes ☐ No or Unknown

Q23. Does the requested compounded medication contain etyl myristoleate, coenzyme q10, methylcobalamin, hyaluronic acid, nicotinamide, methyltetrahydrofolate, ibuprofen, lipoic acid, beta glucan, ubiquinol, chrysin, glutathione, lactobacillus, vitamin E, ascorbic acid, or melatonin?

☐ Yes ☐ No ☐ Unknown

Q24. Does the requested compounded medication contain hydroquinone, acetyl hexapeptide-8, tocopheryl acid succinate, pracasil TM-plus, chrysaderm day cream, chrysaderm night cream, PCCA products, or lipopen ultra?

☐ Yes ☐ No ☐ Unknown

Q25. Is the requested compounded medication being administered topically?

☐ Yes ☐ No or Unknown

Q26. IF YES, then does the requested compounded medication contain ketamine, ketoprofen, diclofenac, morphine, nabumetone, oxycodone, cyclobenzaprine, baclofen, tramadol, hydrocodone, meloxicam, amitriptyline, pentoxifylline, orphenadrine, or piroxicam?

☐ Yes ☐ No ☐ Unknown

Q27. For medical necessity reviews, you must provide a unique peer-reviewed journal article to support a request for off-label use. Please attach any medical information that may support approval.

Q28. Please provide any supporting clinical statements (such as chart notes, lab values, adverse outcomes, treatment failures, or any other additional clinical information) to support an authorization request.

Prescriber Signature

Date

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