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**CAREFIRST
Compounded Drug Products**

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Compounded Drug Products .

Patient Name: _____ **Date:** 12/26/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:** _____
 _____ **NPI#:** _____ **Specialty:** _____
 _____ **Physician Office Telephone:** _____
Physician Office Address: _____

Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____

Please check the appropriate answer for each applicable question.

- | | | | | | |
|-----|--|---|--------------------------|---|--------------------------|
| 1. | Is this request for ANY of the following: A) intravenous (IV) injection or infusion, B) anti-infective for injectable use, C) total parenteral nutrition (TPN), D) leuprolide acetate for infertility in a patient unable to utilize the FDA-approved commercially available product (1 mg per 0.2 mL kit), E) pyrimethamine, F) sirolimus for tuberous sclerosis, where other dermatological treatments, (e.g., laser therapy, surgery, dermabrasion) are inappropriate? [Examples of anti-infectives may include antibacterials, antivirals, antifungals.] | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Is this request for tacrolimus (Prograf) or everolimus (Zortress) for a patient receiving a transplant? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Is the patient 12 years of age or older? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Is this request for a topical compound or a topical compound kit for use on the skin (e.g., cream, gel, lotion, ointment)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Do ANY of the following apply for the requested compound: A) Intended for anti-aging, B) Intended for cosmetic use, C) Is a compound kit, D) Contains a bulk powder, E) Contains a dietary supplement? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Is this request for a hormone therapy compound for menopause OR for androgen decline due to aging (e.g., testosterone, estrogen, progestin, bioidentical hormone)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | Are each of the active ingredients in the compound FDA-approved drugs? [Examples of products that typically do not get FDA approval include bulk ingredients, dietary supplements, vitamin and mineral products, botanical or herbal products, amino acid products, enzyme supplements.] | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 8. | Are each of the active ingredients in the compound FDA-approved for the indication for which the compound is being prescribed? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 9. | Is the compound route of administration (ROA) the same as the FDA-approved route of administration for each active ingredient? [Examples of ROAs include mucosal, oral, parenteral (by injection), inhalation, topical/dermal.] | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 10. | Is the dosage or concentration of each active ingredient in the compound equal to or below the FDA-approved dosage or concentration? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 11. | Is there a current supply shortage of the commercially manufactured product? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 12. | Does the patient have a medical need for a dosage form or dosage strength that is not available commercially or manufactured? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |



- 13. Has the patient had an intolerance or contraindication to the commercially manufactured product (examples may include allergen or adverse effects due to inactive ingredients)? Y N
- 14. Has the commercial product been discontinued by the pharmaceutical manufacturer for reasons other than lack of safety or effectiveness? Y N
- 15. Does the patient need more than 1 fill per month of the compounded drug (necessity may include continuation of antibiotic therapy, stability is less than a month, dose adjustment)? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.