LIVINITI
formerly Southern Scripts

# COMPOUND PRIOR AUTHORIZATION FORM
## FAX NUMBER: 318-214-4190

FOR **URGENT REQUESTS**, please call 800-710-9341.
Regular Hours: M-F 7:00am-5:00pm (Central Time Zone)

☐ **PLEASE MARK ✓ FOR EXPEDITED REVIEW**

| DATE OF REQUEST | OFFICE CONTACT PERSON | OFFICE PHONE NUMBER |
|---|---|---|
| Date: | Name: | Phone Number: |

| MEMBER INFORMATION (REQUIRED) | PROVIDER INFORMATION (REQUIRED) | |
|---|---|---|
| Name: | Provider Name: | |
| DOB: | NPI #: | Specialty: |
| Rx Group #: | Office Phone #: | Is FAX secured? ☐ YES ☐ NO |
| Southern Scripts ID: | Office Fax #: | |
| Phone #: | Office Address (Street, City, State, Zip Code): | |

| PHARMACY INFORMATION | | |
|---|---|---|
| Pharmacy Name: | Prescription #: | Claim #: |
| Pharmacy Phone #: | Pharmacy Fax #: | |

**MEDICATION INFORMATION (REQUIRED)**

**** MUST BE COMPLETED. INCOMPLETE FORMS WILL BE DENIED! ****

Compounds are **not approved** for topical formulations containing **flurbiprofen, gabapentin and ketamine** due to lack of clinical efficacy and safety data, and/or standardized dosages and formulations.

| Member Diagnosis: | ICD-10 Code: | Anticipated Length of Therapy: | Route of Administration: |
|---|---|---|---|
| | | | |

| COMPOUND REQUESTED | COMPOUND INGREDIENT NAME | NDC | QTY | UNIT (e.g., mL) |
|---|---|---|---|---|
| **Name:** _____ | | | | |
| | | | | |
| | | | | |
| Please List All Ingredients. Attach an additional sheet if more space is needed. **Note:** If you are changing the compound formulation, send the new order to the pharmacy | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are all the active ingredients in this compound FDA Approved for the condition being treated? ☐ YES ☐ NO
**IF NO, PLEASE ATTACH OR REFERENCE PEER-REVIEWED MEDICAL EVIDENCE THAT THIS TREATMENT IS SAFE AND EFFECTIVE**

Does the patient have evidence of failure, intolerance, contraindication, or inadequate response to conventional therapies for this condition?
☐ YES ☐ NO

**IF YES, PLEASE ATTACH DETAIL INFORMATION (name of medications, doses, and dates of trial).**
**If NO, please explain.**

****Other pertinent information to support this medication is medically necessary, please attach additional information such as progress notes if needed. ****

**I certify that, to the best of my knowledge, the information above is accurate.**

**Prescriber's Signature:**_____ **Date:** _____

**LIVINITI ONLY:**

**Please Return Completed Form to FAX Number: 318-214-4190**