HIGHMARK WHOLECARE

Updated: 09/2020
PARP Approved: 09/2020

Prior Authorization Criteria

Compounds

All requests for compounds require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Compounds Prior Authorization Criteria:

For all requests for Compounds all of the following criteria must be met:

- Documentation by the prescribing physician must include:
  - The indication the medication is being requested to treat
  - Any comparable commercially available preparations of the active ingredient or that contain similar active ingredients that the member has tried and/or failed and why they cannot take these medications
  - The clinical rationale for using a compounded medication versus an FDA approved product
  - Any published or clinical evidence that this compounded prescription is clinically superior to FDA approved existing therapies
- The physician or the pharmacy must document all ingredients that will be used to compound the prescription
- Each of the active ingredients in the compound must be used for an indication that is FDA approved or compendial supported
- Must meet at least 1 of the following:
  - There is a current supply shortage of the commercial product
  - The patient has a medical need for a dosage form or strength that is not commercially available
  - The patient had a trial and intolerance or contraindication to the commercially available product
  - The commercially available product has been discontinued by the manufacturer for reasons other than lack of safety or effectiveness
- If there are FDA-approved therapies or other standard therapies for the medical condition being treated, such therapies must have been tried and failed or been contraindicated for the patient. (Medication usage must be documented in patient's medical records)
- Prior authorization criteria will apply to all compounded products that exceed a cost threshold of one hundred and fifty dollars ($150) per claim
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
  - Requires documentation demonstrating improvement in condition and tolerance to therapy
  - If previously approved due to shortage or discontinuation of the commercial product, a commercial product must still be unattainable at time of reauthorization
- **Reauthorization Duration of Approval:** 6 months

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION	
Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION	
Member Name:	DOB:
Member ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION	
Medication Ingredients:	
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____)

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information	
Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: _____

Please provide your clinical rationale for using a compounded prescription over a FDA approved product:

_____
_____
_____
_____
_____
_____
_____
_____

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MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Member weight: _____pounds or _____kg

CURRENT or PREVIOUS THERAPY

Has the member tried and failed either of the following? **If yes**, please provide more information below.
☐ Non-pharmacologic therapies
☐ Medications

Medication/Therapy Name	Dose/ Frequency	Dates of Therapy	Reason therapy failed, discontinued, contraindicated, or unattainable

REAUTHORIZATION

Is the commercial product currently unattainable due to shortage or discontinuation? ☐ Yes ☐ No
Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date