BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

# QUALIFIED HEALTH PLAN (QHP) FORMULARY COMPOUNDED MEDICATION REQUEST FORM

**Fax completed form to: (602) 864-3126,** or
email to: pharmacyprecert@azblue.com

**All fields must be completed and legible for review. Incomplete forms will be returned. Office notes relevant to the request that show medical justification are required.** Call (866) 325-1794 to check the status of a request.

**Section 1: Dispensing Pharmacy Information**

Name: _____ NPI: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

**Section 2: Prescribing Provider Information**

Name: _____ NPI: _____

Phone: _____ Fax: _____ Email: _____

**Section 3: Patient Information**

First & Last Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

**IMPORTANT! This form does not apply to FEP or other states' Blues Plans ►** BCBSAZ ID: _____ Group ID: _____

**Section 4: Ingredients (COPY OF INVOICE REQUIRED for products without a valid NDC – please attach)**

| Active Drug Ingredient | Strength | NDC | Quantity | X Cost/Unit | = Totals |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | Compounding Fee: | | | |
| | | Total Cost for Compound: | | | |

**Section 5: Method of Compounding (COPY OF RECIPE REQUIRED – please attach)** Document any additional information or deviation from recipe below.

Time to prepare: _____ Hours and _____ Minutes

**Section 6: Prescription Information (COPY OF ORIGINAL PRESCRIPTION REQUIRED – please attach)**

Final Product Name: _____ Form: _____ Strength: _____

Directions: _____ Duration of Use: _____ Quantity: _____ Day Supply: _____

ICD-10 Code: _____ Diagnosis Description: _____

**Section 7: Reason(s) for a Non-formulary Exception Request: Please check all that apply and provide specific information where indicated.**

**A.** ☐ Yes ☐ No **This medication was started on recent hospital discharge or emergency room visit.** A medication started on recent Hospital Discharge or Emergency Room visit will receive a temporary authorization. Continuation beyond this period will require use of this form and must be accompanied with medical justification for continued use.

**B.** ☐ Yes ☐ No There is no formulary agent in this drug class or other formulary agent in an alternative drug class available to treat this medical condition.

**C.** ☐ Yes ☐ No There is a need for a different dosage form and/or higher dosage. **If checked, indicate/describe need in Section 9.**

**D.** ☐ Yes ☐ No Formulary drug(s) was/were used previously. **If checked, indicate which drug(s) was/were used in Section 8.**

**E.** ☐ Yes ☐ No Formulary drug(s) resulted in therapeutic failure after adequate dose and duration of use. **If checked, indicate dose and duration used in Section 8.**

**F.** ☐ Yes ☐ No Formulary drug(s) produced adverse effect(s). **If checked, indicate adverse effect(s) seen in the table below for history of previous use of formulary agents in Section 8.**

**G.** ☐ Yes ☐ No Formulary drug(s) is/are contraindicated. **If checked, indicate/describe contraindication in the table below for history of previous use of formulary agents in Section 8.**

**H.** ☐ Yes ☐ No Formulary drug(s) may provoke an underlying medical condition which would be detrimental to the patient's care or safety. **If checked, indicate medical condition that would be provoked and the impact on the patient's care or safety issue in Section 9.**

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**I.** ☐ Yes ☐ No Formulary drug(s) is/are not suitable due to specific medical condition(s). **If checked, indicate reason not suitable & the specific medical condition in Section 9.**

**J.** ☐ Yes ☐ No Requested drug is required for optimal medication safety and therapeutic efficacy. **If checked, explain safety and efficacy issue in Section 9.**

**K.** ☐ Yes ☐ No This is a complex patient with one or more other chronic conditions who is currently stable and would be at high risk of significant adverse clinical outcome if formulary drug is used. **If checked, indicate what the anticipated significant adverse clinical outcome would be in Section 9.**

**Section 8: History of previous use of formulary agent(s)**

| | Medication Name, Form & Strength | Directions & Duration of Use | Indicate reason(s) for discontinuation: failure, adverse effects seen, or contraindication to formulary agent |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |
| **6.** | | | |
| **7.** | | | |
| **8.** | | | |
| **9.** | | | |
| **10.** | | | |

**Section 9: Medical rationale/justification for non-formulary exception:** Explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

**Supporting documentation has been included with this request**

☐ Yes ☐ No Office notes relevant to the request that show medical justification have been included with this request **(required)**

**Section 10: Dispensing Pharmacist or Prescribing Provider Attestation, signature certifies that information is complete and correct to the best of my knowledge.**

Signature: _____ Date: _____

**Section 11: Turn-Around Time For Review (check one)**

☐ Standard ☐ Urgent ☐ Exigent (requires prescriber to include a written statement)

**IMPORTANT REMINDER**

Make sure the following documents are included with this form:

1. Copy of Invoice for products without a valid NDC
2. Copy of Recipe
3. Copy of Original Prescription
4. Office notes from the provider relevant to the request that show medical justification are required by BCBSAZ

**Do not write below this line (for BCBSAZ use only)**