Print Reset

Magellan Rx MANAGEMENT

NYRx the Medicaid Pharmacy Program

Topical Compounds Prior Authorization (PA) Worksheet

Fax Number: 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Member Name**, **DOB**, **ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

ENROLLEE INFORMATION

Enrollee's Last Name: _____

Enrollee's First Name: _____

Date of Birth: _____

Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter): _____

PRESCRIBER INFORMATION

Prescriber's Last Name: _____

Prescriber's First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber's Phone Number: _____

Prescriber's Fax Number: _____

CLINICAL CRITERIA FOR TOPICAL COMPOUNDS

(This section must be completed before a prior authorization will be issued.)

1. What is the condition this compound is intended to treat? _____
2. Please provide the route of administration for the compound:
   ☐ Topical ☐ Oral ☐ Other Specify: _____
3. Is a similar commercially-available product available?
   ☐ Yes ☐ No
   If **YES**, please indicate why a commercially-available product is not acceptable and include the specific need for the compound: _____
4. Is the active ingredient(s) of the compound FDA-approved for the condition being treated in the requested route of administration?
   ☐ Yes ☐ No
   If **NO**, please attach and submit peer-reviewed medical evidence for support.
5. Has the patient failed other therapies for this diagnosis?
   ☐ Yes ☐ No If **YES**, please provide the previously failed therapies:

Enrollee's Last Name: **Enrollee's First Name:**

List the NDC, name, dosage form, strength, and quantity of each ingredient. Each ingredient used in the compound MUST be listed. Begin the list with the covered legend drugs.

Please attach an additional form if compound has greater than 10 ingredients.

Rx Required	Active Ingredient	Base/ Vehicle	Excipient/ Other	NDC	Drug Name	Dosage Form/ Strength	Quantity
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

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Prior Authorization Call Line: 1-877-309-9493

Billing Questions: 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.