BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

COMPOUND COVERAGE AUTHORIZATION REQUEST FORM

To ensure timely processing, fill out the following information completely. Fax the signed and completed form to: 1-866-606-6021.

Date of Request M M – D D – Y Y Y Y

When dispensing a compound, use the National Drug Code (NDC) for the most abundant component in the compound and indicate "compound dispensed" when filling. The compound must NOT be commercially available as a legend or over-the-counter medication. In addition, compounded medications must be medically necessary and are subject to review.

Patient Information

Contract Number	Date of Birth	Sex:
	M M – D D – Y Y Y Y	☐ Male ☐ Female

Last Name	First Name	Middle Initial

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:		

Method of Compounding (COPY OF RECIPE REQUIRED – please attach)

Document any additional information or deviation from recipe below.

Time to Prepare: _____ hr(s) and _____ mins

Prescription Information (COPY OF ORIGINAL PRESCRIPTION REQUIRED – please attach)

Final Product Name	Strength	Dosage Form	Dosing Regimen	Total Quantity	Days Supply

Diagnosis or Indication of Use

Prescriber Information

Physician Name	Individual National Provider Number (NPI)

Pharmacy Information

Pharmacy Name	NAPB Number

Contact Name	Office Telephone	Fax Number

I certify this information is complete and correct to the best of my knowledge.

_____ Signature

_____ Title

_____ Date

(06/2010)